



RYAN CONSTANTINE, MD
PLASTIC, RECONSTRUCTIVE & HAND SURGERY

NEW PATIENT MEDICAL HISTORY FORM

Full Name: _____ Date: _____

Birth Date: _____ Age: _____

ALLERGIES NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS <i>(Please list ALL)</i>	DOSE <i>(Mg., pill, etc.)</i>	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information



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PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer (<i>type: _____</i>)			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (<i>type: _____</i>)			
Emphysema (<i>COPD</i>)			
Heart Disease			
High Blood Pressure (<i>hypertension</i>)			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal (<i>kidney</i>) Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE (<i>specify left/right</i>)	DATE	LOCATION/FACILITY

Patient Name: _____ DOB: _____



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FAMILY MEDICAL HISTORY

NO SIGNIFICANT FAMILY HISTORY IS KNOWN

CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (type: _____)	Bleeding Problems	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Anesthesia Complications	Other: _____	Other: _____	Other: _____
Mother																		
Father																		
Brother																		
Sister																		
GM (M or P)																		
GF (M or P)																		

SOCIAL HISTORY

Occupation (or prior occupation):	<input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> LOA <input type="checkbox"/> Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status (check one): <input type="checkbox"/> Single <input type="checkbox"/> Partner <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other: _____	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N (If you never smoked, please move to Alcohol /Drug Use)		
Current: Packs/day _____ # of Years _____	Past: Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco (check one): <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Snuff <input type="checkbox"/> Chew <input type="checkbox"/> Vape			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N		Have you ever used needles to inject drugs? Y N	
Have you ever taken someone else's drugs? Y N			

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REVIEW OF SYSTEMS CHECK ALL THAT APPLY

CONSTITUTION		CARDIOVASCULAR		SKIN	
<input type="checkbox"/>	Activity change	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Color change
<input type="checkbox"/>	Appetite change	<input type="checkbox"/>	Leg swelling	<input type="checkbox"/>	Pallor
<input type="checkbox"/>	Chills	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Rash
<input type="checkbox"/>	Diaphoresis	Gastrointestinal		<input type="checkbox"/>	Wound
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Abdominal distention	ALLERGY/IMMUNO	
<input type="checkbox"/>	Fever	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	Environmental allergies
<input type="checkbox"/>	Unexpected weight change	<input type="checkbox"/>	Anal bleeding	<input type="checkbox"/>	Food allergies
HEAD, EAR, NOSE & THROAT		<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	Immunocompromised
<input type="checkbox"/>	Congestion	<input type="checkbox"/>	Constipation	NEUROLOGICAL	
<input type="checkbox"/>	Dental problem	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Drooling	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Facial asymmetry
<input type="checkbox"/>	Ear discharge	<input type="checkbox"/>	Rectal pain	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Ear pain	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Light-headedness
<input type="checkbox"/>	Facial swelling	ENDOCRINE		<input type="checkbox"/>	Numbness
<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	Cold intolerance	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Mouth sores	<input type="checkbox"/>	Heat intolerance	<input type="checkbox"/>	Speech difficulty
<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	Polydipsia	<input type="checkbox"/>	Syncope
<input type="checkbox"/>	Postnasal drip	<input type="checkbox"/>	Polyphagia	<input type="checkbox"/>	Tremors
<input type="checkbox"/>	Rhinorrhea	<input type="checkbox"/>	Polyuria	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	Sinus pressure	Genitourinary		HEMATOLOGIC	
<input type="checkbox"/>	Sneezing	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	Adenopathy
<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	Dysuria	<input type="checkbox"/>	Bruises/bleeds easily
<input type="checkbox"/>	Tinnitus	<input type="checkbox"/>	Enuresis	PSYCHIATRIC	
<input type="checkbox"/>	Trouble swallowing	<input type="checkbox"/>	Flank pain	<input type="checkbox"/>	Agitation
<input type="checkbox"/>	Voice change	<input type="checkbox"/>	Frequency	<input type="checkbox"/>	Behavior problem
EYES		<input type="checkbox"/>	Genital sore	<input type="checkbox"/>	Confusion
<input type="checkbox"/>	Eye discharge	<input type="checkbox"/>	Hematuria	<input type="checkbox"/>	Decreased concentration
<input type="checkbox"/>	Eye itching	<input type="checkbox"/>	Penile discharge	<input type="checkbox"/>	Dysphoric mood
<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	Penile pain	<input type="checkbox"/>	Hallucinations
<input type="checkbox"/>	Eye redness	<input type="checkbox"/>	Penile swelling	<input type="checkbox"/>	Hyperactive
<input type="checkbox"/>	Photophobia	<input type="checkbox"/>	Scrotal swelling	<input type="checkbox"/>	Nervous/anxious
<input type="checkbox"/>	Visual disturbance	<input type="checkbox"/>	Testicular pain	<input type="checkbox"/>	Self-injury
RESPIRATORY		<input type="checkbox"/>	Urgency	<input type="checkbox"/>	Sleep disturbance
<input type="checkbox"/>	Apnea	<input type="checkbox"/>	Urine decreased	<input type="checkbox"/>	Suicidal ideas
<input type="checkbox"/>	Chest tightness	MUSCULAR			
<input type="checkbox"/>	Choking	<input type="checkbox"/>	Arthralgias		
<input type="checkbox"/>	Cough	<input type="checkbox"/>	Back pain		
<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Gait problems		
<input type="checkbox"/>	Stridor	<input type="checkbox"/>	Joint swelling		
<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Myalgias		
<input type="checkbox"/>		<input type="checkbox"/>	Neck pain		
<input type="checkbox"/>		<input type="checkbox"/>	Neck stiffness		

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