JAY S. ORRINGER, M.D.
A Professional Corporation
Plastic and Reconstructive Surgery

Medical History

Name _____ Home Ph # _____ Wk # _____

Family Physician, if any? _____ Address and phone #, if available_____

Who referred you to Dr. Orringer? _____ Phone # available_____

May we send a thank you letter to your referral?_____

What problem brings you to see Dr. Orringer?_____

Please check all that apply. I have or have had:

____ Anemia (low blood count)

____ AIDS or exposure to AIDS

____ Asthma/bronchitis/emphysema/other breathing problems

____ Bleeding problems, including easy bruising, blood in urine, stool, sputum, excessive bleeding associated with surgery or injury

____ Cancer

____ Diabetes

____ Glaucoma

____ Heart problems (heart attack, chest pain, irregular heart beat, heart murmur)

____ Hepatitis or exposure to hepatitis, jaundice (yellowing of the skin), other liver problem

____ High blood pressure

____ Kidney problems, urinary infections, bladder or prostate problems

____ Scarlet fever or rheumatic fever

____ Significant emotional problems

____ Psychiatric care or advised to see psychiatrist

____ Adverse reaction to local or general anesthetic

____ Allergy to adhesive tape

____ Problems with poor healing

____Large scars or keloids

____ Frequent skin infections or boils

____ Current sore throat or cold

____ Family history of problems associated with surgery or anesthesia

____ Other health problem(s)

Please explain any checked:_____

_____

_____ _____
Signature Date

Medication/Allergies

Please list all medications you are now taking or recently took (including blood pressure or heart medications, water pills, birth control pills, hormones, blood thinners, aspirin, bufferin, arthritis medications, sleeping pills, etc.)

Medications	Amount taken?	How often?

Do you have a history of addiction to narcotics, sedatives or alcohol? _____
Approximate daily consumption of alcohol? _____ Tobacco _____
If you quit smoking, when did you quit? _____
How much did you smoke? _____
Do you have allergies to any medications? _____
If yes, which medications? _____
Allergies to other substances? _____ Which? _____
Allergy to Iodine, x-ray dye or seafood? _____ Which? _____

Please list all previous surgery:

Operation	Approximate Date	Hospital	Surgeon's Name	Local or General Anes.

List problems associated with previous surgery or anesthesia:

_____

_____

_____

_____

Signature *Date*