



Your Medical History

Please help us assure you the highest quality care by answering carefully.

Gloria Duda, MD, PC
Plastic Surgery
703-893-1111

Date: _____ Name: _____ Age _____ Ht. _____ Wt. _____

Are you currently being treated for any illness? _____

Circle any medical problems you have or have been treated for:

NO SIGNIFICANT ILLNESSES	GASTROINTESTINAL	EXTREMITIES	INFECTIOUS DISEASE
HEAD/NECK	Gastric Esophageal Reflux Disease	Arthritis-Osteo	Herpes/Fever blisters
Cataracts	Hiatal hernia	Arthritis-Rheumatoid	HIV
Glaucoma	Irritable bowel syndrome	Deep venous thrombosis/blood clot	MRSA
HEART	Ulcer disease	Fibromyalgias	CANCER
Heart attack	LIVER	Varicose veins	Breast
Heart disease	Gall stones	ENDOCRINE	Breast Genetic Susceptibility
High blood pressure	Hepatitis A	Diabetes mellitus: insulin dependent	Colon
Hypercholesterolemia	Hepatitis B	Diabetes mellitus: noninsulin	Liver
Mitral valve prolapse	Hepatitis C	Diabetes mellitus: diet controlled	Lung
Rheumatic fever	Hepatitis (unkown type)	Hyperthyroid	Melanoma
Stroke	Jaundice	Hypothyroid	Ovarian
PULMONARY	GENITOURINARY	HEMATOLOGIC	Skin
Asthma	Kidney disease	Anemia	OTHER:
Bronchitis	Kidney stones	Excessive blood clotting	
Chronic Obstructive Pulm Disease	NEUROLOGIC/PSYCHIATRIC	Factor 5 deficiency	
Emphysema	Depression	Protein S deficiency	
Pneumonia	Psychiatric disorders	Protein C deficiency	
Pulmonary embolus	Seizures	Antithrombin deficiency	
Sleep disorder/apnea		Hemophilia	
		Von Willebrand's	

Circle any problems you have or have had:

HEAD and NECK	CARDIOVASCULAR	PULMONARY	OTHER
Headaches	Chest pain	Shortness of breath	Fainting or blackout episodes
Migraines	Heart murmur or disorder	Chronic cough	Prolonged bleeding when cut
Sinusitis	Irregular heart beat	UROLOGIC	Easy bruising
Blurred vision or Double vision	GASTROINTESTINAL	Pain with urination	Cold or Heat intolerance
Visual problems	Change in bowel habits	Blood in urine	Leg swelling
Dry eyes	Weight gain or loss	Frequent urination	Rashes
Wear contact lenses	Nausea or vomiting	Incontinence	Keloid or Poor scar
Wear dentures or partial	Abdominal pain	NEUROLOGIC	OTHER:
Have capped teeth	Blood in stool	Numbness or tingling	
Hearing loss	Appetite change	Panic attacks or anxiety	
Limited neck mobility	Indigestion	Seizures	
		Weakness	

Previous surgeries you have had:

OPERATION	DATE	OPERATION	DATE

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List all medications you are taking: include over the counter preparations such as aspirin, antihistamines, motrin, anti-inflammatories, diuretics, birth control or herbal and alternative medications

MEDICATION/DOSE	FREQUENCY	MEDICATION/DOSE	FREQUENCY

Are you allergic or have reactions to medications, drugs, or local anesthetic medications?

MEDICATION	REACTION	MEDICATION	REACTION

Allergy to: LATEX, TAPE, EGGS?

Have you ever had a reaction to anesthesia? No Yes

What type of reaction? _____

Have you ever received a blood transfusion? No Yes

Did you have a reaction? _____

Do you smoke? No Yes _____ packs per day

Have you smoked in the past? No Yes _____ packs per day; When did you quit? _____

Are you exposed to secondary smoke? No Yes

Do you drink alcoholic beverages? No Occasionally Regularly _____ drinks per day/weeks

Do you exercise? No Yes How long/How often? _____

WOMEN ONLY

Is there any chance that you are pregnant? No Yes Are you breastfeeding? No Yes

Number of pregnancies _____ Date of last menstrual period _____

Date of last mammogram _____

Circle any problems a family member has had:

	FAMILY MEMBER		FAMILY MEMBER
Abnormal bleeding/Blood Clot		Heart disease	
Abnormal clotting		Hemophilia	
Anesthesia problems		High blood pressure	
Autoimmune disorders		Kidney disease	
Cancer		Hepatitis	
Diabetes mellitus: insulin dependent		Liver disease	
Diabetes mellitus: noninsulin depend		Lung disease	
Diabetes mellitus: diet controlled		Malignant hyperthermia	
Diabetes mellitus: unknown type		Stroke	
Endocrine disease		von Willebrand's disease	
Heart attack			

Name of personal/regular physician: _____

Address: _____

Telephone: _____

Date of last exam: _____