



**B L A C K H I L L S
PLASTIC SURGERY, P.C.**

Robert J. Schutz, M.D.

PERSONAL HISTORY

This information is **confidential** and will not be released except with your authorization.

DATE: _____

NAME: _____ ADDRESS: _____

Phone: _____ Ht.: _____ Wt.: _____ Sex: F M Birthdate: _____

Date of last Physical Exam: _____ Doctor: _____

Doctor's Address: _____ Doctor's Phone: _____

Date of last EKG: _____ Chest X-Ray: _____ Lab Work: _____

PAST MEDICAL HISTORY: HAVE YOU HAD PROBLEMS WITH: (CIRCLE YES OR NO)

| | | | | | |
|---------------------|----|-----|------------------|----|-----|
| HIV or AIDS Related | No | Yes | Blood Pressure | No | Yes |
| Thyroid | No | Yes | Asthma | No | Yes |
| Heart | No | Yes | Stroke | No | Yes |
| Lungs | No | Yes | Cancer | No | Yes |
| Kidneys | No | Yes | Hepatitis | No | Yes |
| Bladder | No | Yes | Nervous Problem | No | Yes |
| Gall Bladder | No | Yes | Bleeding Problem | No | Yes |
| Stomach | No | Yes | Arthritis | No | Yes |
| Diabetes | No | Yes | Heavy Bleeding? | No | Yes |
| Regular menses? | No | Yes | | | |

No Yes Do you smoke cigarettes? Packs/day? _____ How many years? _____

No Yes Do you drink over 3 cups/coffee/day? How much? _____

No Yes Do you regularly drink alcohol or beer? How much? _____

MEDICATIONS: PLEASE CIRCLE DRUGS YOU ARE TAKING.

| | | | | | |
|--------------------|----|-----|-------------------------|----|-----|
| Aspirin/Anacin | No | Yes | Insulin | No | Yes |
| Bufferin | No | Yes | Blood thinners | No | Yes |
| Motrin | No | Yes | Antibiotics | No | Yes |
| Ibuprophen | No | Yes | Birth Control | No | Yes |
| Arthritis Medicine | No | Yes | Other medications _____ | | |

Aspirin and aspirin type products can cause excessive bleeding during surgery.

DRUGS OR SUBSTANCES TO WHICH YOU ARE ALLERGIC: _____

FAMILY HISTORY: HAVE BLOOD RELATIVES HAD: PLEASE CIRCLE & GIVE RELATION

| | | | | | |
|-------------------|----|-----------|-----------|----|-----------|
| Diabetes | No | Yes _____ | Arthritis | No | Yes _____ |
| Bleeding Disorder | No | Yes _____ | Asthma | No | Yes _____ |
| Cancer | No | Yes _____ | Stroke | No | Yes _____ |

PLEASE LIST ANY SERIOUS ILLNESSES OR INJURIES AND DATE:

Illness/Injury _____ Year _____ Illness/Injury _____ Year _____

OPERATIONS: PLEASE LIST OPERATIONS AND YEAR:

Operation _____ Year _____ Operation _____ Year _____
 Operation _____ Year _____ Operation _____ Year _____

COMPLETE THE FOLLOWING SECTION ONLY IF YOU HAVE BREAST PROBLEMS.

Breast Problems: _____

| | | | | |
|----------------------|----------------|-----------------------------------|-----|------------|
| Last Mammogram _____ | Date _____ | Breast Cancer _____ | R L | Date _____ |
| Breast Lumps _____ | R L Date _____ | Mastectomy _____ | | Date _____ |
| Fibrocystic _____ | R L Date _____ | Radiation Therapy Completed _____ | | Date _____ |
| Breast Biopsy _____ | R L Date _____ | Chemotherapy Completed _____ | | Date _____ |
| Surgeon _____ | | Oncologist _____ | | |
| Address _____ | | Address _____ | | |

NOTES: