DAVID M. GODAT, MD
Plastic Surgery

New Patient Medical Information (date____/_____/____):
Reason for consultation ____**Age:** _____________
Height_____ Weight_____ Normal weight is_____ Last time at this weight____________________
Allergies or intolerance to medications____
Medications: include name, dosage, and length of time: ____________________________________
____
Over the counter medications taken including aspirin, diet pills, vitamins, & herbs _______________
____
Medical History ____
____
Surgical History____
____
Anesthesia problems ____
Past hospitalizations and dates (include childbirth)____
____

Have you ever had?	Yes	No	Have you ever had?	Yes	No
Seizures or epilepsy			Asthma		
Any other neurological disorder			Any other pulmonary disorders		
Cancer			Stroke		
Immune disorders			Peripheral vascular disease		
Anemia			Ulcers		
Any other blood disorders			Diabetes		
High blood pressure			Thyroid problems		
Mitral valve prolapse			Hepatitis/jaundice		
Angina			Kidney problems		
Heart attack			Urinary tract disorders		
Heart failure			Depression or other mood disorder		
Shortness of breath			Alcohol or drug dependency		
Emphysema			Anxiety disorder		

Do drink alcohol? Yes____No____ 1-3/4-6/more than 6 drinks per occasion; ___times per wk/mo
Do you use any other substances recreationally? Yes ___ No ____What, how much, how often? ____
Do you smoke ? Yes ____No ____ Packs per day ____For how long? _____months/years
Do you use any other tobacco? What, how much and how often?_____________________________
For how long have you stopped using all tobacco products? ______mo./yrs. Nicotine patch dose_____
Have you ever had any testing for the following?
Tuberculosis Yes_____ No _____ Date__________ Results_______________
HIV Yes_____ No _____ Date__________ Results_______________
Hepatitis Yes_____ No _____ Date__________ Results_______________
Family history of cancer/heart disease/diabetes, other? Explain_________________________________
____
Date of last physical exam ________ Physician_______________________ Phone_______________
Last EKG __________________ Chest X-ray _________________ Blood work__________________
Mammogram _______________ Any findings? ____

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