Toby R. Meltzer MD, PC
7025 N. Scottsdale Road Suite 302
Scottsdale, Arizona 85253

Plastic and Reconstructive Surgery
480.657.7006 Office
866.876.6329 Toll-Free
480.657.7020 FAX

Health History

First Name ______________________ MI ___ Last Name _________________________ Date _______________________

____
Home Address

____
City State Zip Code

Home Phone ___________________________ Work Phone ________________________ Cell Phone: ___________________

Email ____ Okay to send confidential information to email _____ yes _____ no

Occupation ____________________________________ Date of Birth _______________ Age ______ Height ______ Weight ______

Primary Therapist Name and Number: ____

1. **Please list all food and drug allergies:** ____

2. **Please list all prescriptions and non-prescription drugs you take on a daily basis (including street drugs, eye drops, herbal remedies, etc.)**

DRUG	DOSE	HOW OFTEN	PRESCRIBED FOR:
:			

3. **Please list all operations, type of anesthetic used General (asleep); Spinal (numb from waist down); IV SEDATION OR Local (just one area that was numb such as a hand or foot), and the appropriate date:**

Surgery Type	Anesthesia Type	Year

Print Patient Name: ____

4. Do you:

	YES	NO
• Smoke --- If yes, how much? ________________	___	___
• Drink beer, wine or hard liquor? If yes, how much? ____________	___	___

5. Do you have or have you ever had any of the following: (if yes to any, please circle which one)

	YES	NO
• High Blood Pressure	___	___
• Asthma/Breathing Problems	___	___
• Kidney Problems	___	___
• Liver Problems	___	___
• Heart Problems	___	___
• Neurological Problems	___	___
• Vision Problems	___	___
• Hearing Problems	___	___
• Prostate Problems	___	___
• Urinary Tract Infections	___	___
• Problems Urinating or Urethral Stricture	___	___
• Deep Vein Thrombosis/DVT	___	___
• Blood Clots in Lung or Legs	___	___
• Any Bleeding Problems	___	___
• Arthritis	___	___
• Mobility/Joint Problems	___	___
• Diabetes	___	___
• Personal or Family History of Breast Disease	___	___
• Thyroid Problems	___	___
• Sexually Transmitted Disease(s)	___	___
• Genital Herpes	___	___
• Oral Herpes	___	___
• HIV	___	___
• Hepatitis	___	___
• Cancer	___	___

Print Patient Name: ____

6. **Have you ever had problems during surgery or following surgery with your anesthesia? Such as: Nausea, vomiting, difficulty breathing, or fever?** **Yes ________ No ________________**

7. **Please explain any YES answers or describe any health related issues not listed:**

____

____

____

Do you have any questions or concerns regarding your anesthetic? **Yes _________ No ________________**

If so, list all questions or concerns: ____

____

Do you object to a blood transfusion? **Yes __________ No _______________**

____ _________________________________

Signature of Patient **Date**

Reviewed and Updated on Preoperative Appointment:

____ ___________________________________

Signature **Date**