Cynthia M. Goodman, M.D.

Plastic & Reconstructive Surgery

History Intake Form

Name:____Date of Birth:________________________

Name of Primary Care Physician:____

Date of last exam:________________________________By Whom:__________________________

Weight:____________________Height:______________

Name of psychiatrist:______________________________Last seen:__________________________

Please list all previous surgeries or major illnesses and dates: _________________________________

____

____

Please list any drug allergies:____

Please list any medications taken regularly (including: aspirin, herbals and vitamins)

____

____

Do you have any bleeding tendencies? ____

Do you smoke, if so, amount per day or date you quit if you are a former smoker: _________________

Do you drink, if so, amount per day: _______________________

Past Medical History **Please check if you have ever had any of the following:**

Mitral Valve Prolapse:___	**Cancer: ___**	**Heart Disease: ___**	**Stroke: ___**	**Asthma: ___**
Cold Sores: ___	**Anemia: ___**	**Arthritis: ___**	**High Blood Pressure: ___**	**Depression: ___**
Stomach Ulcer: ___	**Diabetes: ___**	**Schizophrenia: ___**	**Bipolar Disease: ___**	**HIV/AIDS: ___**
Thyroid ____				

Please list any other medical problems: ____

____

Family History **Please check if any blood relatives have ever had any of the following:**

Breast Cancer: ___	**Melanoma: ___**	**Stroke: ___**	**High Blood Pressure: __**
Heart Disease: ___	**Diabetes: ___**	**Kidney Disease: ___**	**Depression: ___**

For Women Only

Date of last mammogram: __________ Any breast lumps or discharge? ___________

Number of pregnancies: _________ Did you breast feed? _____________

I verify that the above information is true and correct to the best of my knowledge.

Signature: ____ Date: ____________________