Charles P. Virden, M.D., F.A.C.S.

COSMETIC & RECONSTRUCTIVE PLASTIC SURGEON

Patient Medical History

PATIENT HISTORY

NAME: _____DOB: _____ AGE: _____ HT: _____ WT: _____

ALLERGIES: _____

PREVIOUS SURGERIES: _____

Anesthesia Problems:	Yes	No	Kidney Problems:	Yes	No
Heart Problems:	Yes	No	Liver Problems:	Yes	No
High Blood Pressure:	Yes	No	Thyroid Problems:	Yes	No
Stroke/Circulatory Problems:	Yes	No	Digestive Problems:	Yes	No
Bleeding Problems:	Yes	No	Visual or Hearing Problems:	Yes	No
Breathing problems:	Yes	No	Hepatitis:	Yes	No Type: _____
Seizures or Epilepsy:	Yes	No	Chronic Pain:	Yes	No Location: _____
Pregnant:	Yes	No	Do You Smoke?	Yes	No Amount? _____
Diabetes:	Yes	No			
Cancer:	Yes	No	History of: ESBL MRSA C. diff VRE N/A		

List Current Medications and Supplements: _____

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Personal Physician: _____ Referring Physician: _____

Patient Signature: _____ Date: _____ Time: _____

NOTES:_____

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