

**HISTORY AND PHYSICAL**  
*Charles A. Wallace, M.D., FACS*

**ALLERGIES:**

Any drug allergies (including local anesthetics and codeine)

Yes

No

If yes, please list drug and reaction type:

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Tape Allergy

Yes

No

**MEDICATIONS:**

List any medications you are presently taking and dosage (within last month):

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Are you taking aspirin or medication containing aspirin?

Yes

No

Have you taken any steroid (cortisone) preparations over the past year?

Yes

No

Are you taking any Vitamin E?

Yes

No

**CHILDHOOD MEDICAL HISTORY:**

Had all known "baby shots"?

Yes

No

Uncertain

Had polio immunization?

Yes

No

Uncertain

Had rheumatic fever?

Yes

No

Uncertain

**SOCIAL:**

Do you smoke?

Yes

No

If so, how many packs a day \_\_\_\_\_

Do you drink more than two drinks per day?

Yes

No

**FAMILY HISTORY:**

Any family history of medical problems or illness?

Mother \_\_\_\_\_

Father \_\_\_\_\_

Sister \_\_\_\_\_

Brother \_\_\_\_\_

**SURGERY: (Operations):**

	Name	Date	Complications or difficulties
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

**ADMISSIONS TO HOSPITAL:**

	Reason	Date	Complications or difficulties
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HISTORY AND PHYSICAL**  
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**Patient Name:** \_\_\_\_\_

**MEDICAL EVALUATION:**

How is your general health? \_\_\_\_\_

Are you presently being treated for any medical conditions? \_\_\_\_\_

\_\_\_\_\_

When was your last physical examination? \_\_\_\_\_

\_\_\_\_\_

**EYE**

Visual loss (one or both eyes)      Yes      No

“Dry” eyes      Yes      No

Itching or irritation of eyes      Yes      No

Blurred or double vision      Yes      No

Crossed or lazy eyes      Yes      No

Cornea problems      Yes      No

Thyroid eye disease      Yes      No

Wear glasses or contacts      Yes      No

Previous eye or eyelid surgery      Yes      No

If yes, what type \_\_\_\_\_

\_\_\_\_\_

**NOSE**

Difficulties breathing through nose      Yes      No

Previous injury to nose      Yes      No

Nasal allergies      Yes      No

Nose bleeds      Yes      No

Sinus conditions      Yes      No

Previous nasal or sinus surgery      Yes      No

If yes, what type \_\_\_\_\_

\_\_\_\_\_

Previous aesthetic plastic surgery      Yes      No

If yes, what type \_\_\_\_\_

\_\_\_\_\_

Irradiation to face or neck      Yes      No

Facial paralysis or weakness      Yes      No

Facial skin problems      Yes      No

Other skin problems      Yes      No

If yes, what type \_\_\_\_\_

\_\_\_\_\_

**BREAST**

Pain or discomfort      Yes      No

Cyst or lump in your breast      Yes      No

Have you had breast biopsies      Yes      No

Family history of breast cancer      Yes      No

If yes, who \_\_\_\_\_

\_\_\_\_\_

Have you had a mammogram      Yes      No

If yes, when \_\_\_\_\_

\_\_\_\_\_

**CARDIOVASCULAR**

Coronary or heart attack      Yes      No

Congenital heart disease      Yes      No

Heart murmur      Yes      No

Palpitations or irregular heart beat      Yes      No

Hypertension      Yes      No

Stroke      Yes      No

**CHEST**

Shortness of breath      Yes      No

Chronic lung disease      Yes      No

Cough      Yes      No

Asthma      Yes      No

**PSYCHIATRIC**

Received psychiatric treatment      Yes      No

If yes, were you hospitalized      Yes      No

Any recent crisis in your life      Yes      No

**OTHER**

Liver disorder (hepatitis, cirrhosis)      Yes      No

Kidney, bladder, or chronic infection      Yes      No

Spinal or back disorders      Yes      No

Blood clots or thrombophlebitis      Yes      No

Bleeding disorders, self or family      Yes      No

Blood transfusion      Yes      No

Diabetes      Yes      No

Autoimmune disease      Yes      No

(lupus, rheumatoid arthritis)      Yes      No

Any unusual scarring or keloid      Yes      No

If applicable, are you pregnant      Yes      No

Stomach or digestive disorder      Yes      No

HIV / AIDS      Yes      No