University Cosmetic & Plastic Surgery Associates

2000 Foundation Way, Suite 3650, Martinsburg, WV 25401 -- (304) 350-3274

J. Richard Casuccio, MD

PATIENT HISTORY

Patient Name: _____ Email Address: _____

Date of Birth: _____ Age: _____ Occupation: _____

How did you hear about us (circle all that apply, please be specific):

Health Care Provider *Friend* *Internet* *Ad* *Other*

_____

1. Please list all medications you take regularly:

   _____ _____

   _____ _____

   _____ _____

2. Please list previous surgeries, cosmetic procedures (including Botox), and date performed:

   _____ _____

   _____ _____

3. Please list all previous illnesses, including childhood diseases, and age at time of illness:

   _____ _____

   _____ _____

4. Please list any accidents and age at the time of injury:

   _____ _____

   _____ _____

5. Please list any medical problems in your family history: (heart disease, cancer, high BP, etc.)

   _____ _____

   _____ _____

6. Have you had a recent weight loss? Yes _____ No _____

7. Do you take Aspirin? Yes _____ No _____
   If so, how frequently? _____

PATIENT NAME: _____ DOB:_____

8. Past & Present Medical History:

A. ALLERGIES/REACTIONS	Yes	No	If yes, please specify to what
Medication	____	____	_____
Skin rash	____	____	_____
Food	____	____	_____
Adhesive Tape	____	____	_____
Aspirin	____	____	_____
Vitamin E	____	____	_____
Non-prescription Drug	____	____	_____
Other (explain)	____	____	_____

B. GENERAL	Yes	No
High Blood Pressure	____	____
Diabetes	____	____
Bruise Easily	____	____
Bleeding Disorder	____	____
Exposure to AIDS or HIV virus	____	____

C. HABITS	Yes	No	If yes, please specify quantity
Smoking	____	____	_____
Alcohol	____	____	_____
Drugs (*please list name*)	____	____	_____

D. HEAD & Neck	Yes	No		Yes	No
Headaches	____	____	Hearing Loss	____	____
Dizzy Spells	____	____	Ringing in Ears	____	____
Failing Vision	____	____	Pain in Ears	____	____
Halos at Night	____	____	Discharge from Ears	____	____
Eye Pain	____	____	Repeated Nose Bleeds	____	____
Double Vision	____	____	Toothache at present	____	____

E. HEART & LUNGS					
Chest Pain	____	____	Pleurisy	____	____
Skipping Heart beats	____	____	Chronic Cough	____	____
Night Sweats	____	____	Cough up Blood	____	____
Heart Defects	____	____	Ankle Swelling	____	____
Difficult Breathing	____	____			

PATIENT NAME: _____ DOB:_____

F. STOMACH & INTESTINES	Yes	No		Yes	No
Chronic Pain	____	____	Vomit Blood	____	____
Nausea	____	____	Skin Turns Yellow	____	____
Heartburn	____	____	Chronic Diarrhea	____	____
Appetite Loss	____	____	Black Tarry Stools	____	____
Rectal Bleeding	____	____	Clay Colored Stools	____	____
Constipation	____	____	Hemorrhoids	____	____

G. URINARY TRACT					
Excess Urination	____	____	Painful Urination	____	____
Urinary Shutdown	____	____	Urine Leakage	____	____
Blood in Urine	____	____	Pass Stones	____	____
Night Urination	____	____	Bedwetting	____	____
Kidney Problems	____	____	Urine Retention	____	____

H. GYNECOLOGICAL					
Are you or could you be pregnant?	____	____	Breastfeeding	____	____
Painful Menstruation	____	____	*currently or in the past?*		
Bleeding between periods	____	____			
Number of Pregnancies	____	____	*how many?* _____		
Number of living children	____	____			
Excess Menstruation	____	____			
Abnormal Periods	____	____			

I. MUSCLES, JOINTS, NERVES		
Neuromuscular Disease	____	____
Tingling sensations	____	____
Numbness	____	____
Strokes	____	____
Nervous Breakdown	____	____
Paralysis	____	____
Shaking	____	____
Speech Disturbances	____	____
Alcohol/Drug Problems	____	____
Mental Problems	____	____
Limited Motion	____	____
Joint Pain	____	____
Disturbance with Walking	____	____
Muscle Jerking	____	____
Memory Loss	____	____
Personality Change	____	____
Seizures	____	____
Varicose Veins	____	____

PATIENT NAME: _____ DOB:_____

9. Any additional information you feel the provider should be aware of that is not listed above:

_____

_____

_____

I certify that the facts/information provided by me above are true and complete to the best of my knowledge.

_____ _____

DATE PATIENT SIGNATURE

_____

PARENT/GUARDIAN SIGNATURE IF PATIENT IS A MINOR

Name of person completing form if other than patient: _____