

# Medical History Form

## Dr. Jay M Pensler

*Please fill out and bring to your consultation or fax prior to (312) 642-3333*

Name \_\_\_\_\_

Date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

**ALLERGIES:** (if yes, please list medication and type of reaction)

\_\_\_\_\_

**MEDICATIONS:** (list prescribing doctor; include hormone replacement, diet pills, ALL VITAMINS AND HERBS ,teas, over-the-counter or alternative therapies. PLEASE INCLUDE ANY ASPIRIN USE AND/OR USE OF ANTI- INFLAMMATORIES.)

Medications (Name of Drug)	Dosages ( How much)	Frequency (How often)

**PAST MEDICAL HISTORY:** Do you have now or have you had in the past any of the following:

	YES	NO
<b>YES</b> <b>NO</b>		
Bleeding	_____	_____
Diabetes	_____	_____
Rheumatic Fever	_____	_____
Asthma	_____	_____
Cough	_____	_____
Heart Disease	_____	_____
Hypertension	_____	_____
Tuberculosis	_____	_____
Jaundice/Hepatitis	_____	_____
GI disease	_____	_____
Neurologic disease	_____	_____
Lung Disease	_____	_____
Steroid use	_____	_____
Convulsions	_____	_____
Kidney disease	_____	_____

**LIST OTHER MEDICAL CONDITIONS:** \_\_\_\_\_

**HAVE YOU EVER BEEN HOSPITALIZED FOR A MEDICAL CONDITION?** (for what and when) \_\_\_\_\_

**PAST SURGERIES:** (list type of surgery, hospital, physician and date/year)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had a REACTION to a GENERAL anesthetic? (being put to sleep)  
Yes            No  
Have you ever had a REACTION to a LOCAL anesthetic? (Novocain, etc.)  
Yes            No  
Do you form heavy scars?  
Yes            No  
Do you have frequent infections or boils?  
Yes            No  
Do you bleed unusually easily (from cuts, surgery, tooth extractions, etc)?  
Yes            No  
Do you bruise easily?  
Yes            No  
Have you ever taken steroid medications, cortisone, or ACTH?  
Yes            No  
Have you ever had any significant emotional problems?  
Yes            No  
Do you have shortness of breath with walking?  
Yes            No  
Have you ever been advised or had psychiatric care?  
Yes            No  
Have you seen other plastic surgeons about the **SAME** problem that brings you here?  
Yes            No  
Are you pregnant?  
Yes            No

**SOCIAL HISTORY** Tobacco (cigarettes, cigars, pipe) [list amount/day and # of years smoking]  
\_\_\_\_\_

Have you been exposed to heavy second hand cigarette, cigar or pipe smoke for an extended period of time on a regular basis in the past two years?            Yes            No  
If you ever smoked but don't now, when did you quit?  
\_\_\_\_\_

**Recreational drugs** (type of drug and number of years of use) \_\_\_\_\_  
\_\_\_\_\_

**Alcohol** (type, how often)  
\_\_\_\_\_

**FAMILY HISTORY** (list relationship, age, medical problem, and if they are living or deceased)

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**Primary Care MD:** Name & Telephone # \_\_\_\_\_

**Pharmacy:** Name & Telephone # \_\_\_\_\_

**Emergency contact person**

\_\_\_\_\_  
Name & Telephone #

**SIGNATURE:**

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RELATIONSHIP TO PATIENT (Self, Parent) \_\_\_\_\_

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