Robert T. Love III, M.D.
MEDICAL HISTORY QUESTIONAIRE

Name ____ Date ____________________

Reason for consultation ____

Are you currently taking any medications? (Y) (N) If so, what?

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Are you allergic to any medications? (Y) (N) If so, what?

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Have you ever had surgery? (Y) (N) If so, what procedure?

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If you are a breast reconstruction patient, did you have chemotherapy or radiation? ____
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Have you ever had a mammogram? (Y) (N) Date of last one? ______________

Do you smoke? (Y) (N) How much? ________________________________

Do you use a nicotine patch or nicotine gum? (Y) (N) Which one? ______________

What is your height? ______________________ Weight? ________________________

If deemed necessary by my surgeon, I agree to the testing for the HIV virus? Y/N

DO YOU OR HAVE YOU EVER HAD:

- ☐ AIDS or HIV
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Tendency
- ☐ Cancer
- ☐ Emotional Problems
- ☐ Eye Problems
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Seizures
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Pain, weakness, numbness in arms, back, feet, hands, hips, legs, neck, or shoulders
- ☐ Psychiatric Disorders
- ☐ Stroke
- ☐ Sickle Cell Disease
- ☐ Stomach Ulcers
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Anesthesia Complications

Do you have a family history of any of the above conditions? If yes, please explain ____
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To the best of my knowledge, the above information is correct.

Signature ____ Date ____________