MUNE GOWDA M.D. & ASSOCIATES

Aesthetic Plastic Surgery of the Face & Body
Laser Surgery & Skin Care

26850 Providence Parkway | Suite 125 | Novi, MI 48374
3270 West Big Beaver Road | Suite 415 | Troy, MI 48084
Novi Phone: 248.305.8400 | Fax: 248.305.5880
Troy Phone: 248.530.0000 | Fax: 248.283.5599
gowdamd.com

Patient Name _____ Birth Date _____ Age _____

Height _____ Weight _____ Race _____ Preferred Language *(English, Spanish, etc.)* _____

Preferred Contact Method *(check one):* ☐ Home Phone _____ ☐ Cell _____ ☐ Email _____

Pharmacy Name and Address _____ Pharmacy Phone _____

Primary Care Doctor _____ City, State _____

Did a doctor refer you to our office? Yes/No If yes, whom? _____ City, State _____

PAST MEDICAL HISTORY: Have you EVER had or currently have the following? ☐ No known past medical history.

CONDITION		
Anxiety	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
A Fib *(irregular heartbeat)*	Yes	No
BPH *(enlarged prostate)*	Yes	No
Bone Marrow Transplant	Yes	No
Breast Cancer	Yes	No
Colon Cancer	Yes	No
COPD	Yes	No
Coronary Artery Disease	Yes	No

CONDITION		
Depression	Yes	No
Diabetes	Yes	No
Kidney Disease	Yes	No
Gastric Reflux (GERD)	Yes	No
Hearing Loss	Yes	No
Hepatitis	Yes	No
High Blood Pressure	Yes	No
Controlled w/Medication	Yes	No
HIV/AIDS	Yes	No
High Cholesterol	Yes	No

CONDITION		
Hyperthyroidism	Yes	No
Hypothyroidism	Yes	No
Leukemia	Yes	No
Lung Cancer	Yes	No
Lymphoma	Yes	No
Prostate Cancer	Yes	No
Radiation Treatment	Yes	No
Seizures	Yes	No
Stroke	Yes	No
Other:		No

PAST SURGICAL HISTORY: Have you EVER had the following? ☐ No surgeries.

☐ Appendix Removal *(Appendectomy)*	☐ Heart: Heart Transplant	☐ Ovaries: Ovarian Cyst
☐ Bladder Removal *(Cystectomy)*	☐ Heart: Mechanical Valve Replacement	☐ Ovaries: Tubal Ligation
☐ Breast: Biopsy	☐ Heart: Attack/Stents *(PTCA)*	☐ Prostate: Biopsy
☐ Breast: Lumpectomy ☐Left ☐Right ☐Both	☐ Joint Replacement: Hip ☐ Left ☐ Right ☐Both	☐ Prostate: Cancer
☐ Breast: Mastectomy ☐Left ☐Right ☐Both	☐ Joint Replacement: Knee ☐ Left ☐ Right ☐Both	☐ Prostate Removal *(Prostatectomy)*
☐ Colon: Colectomy	☐ Kidney: Biopsy	☐ Prostate: TURP
☐ Colon Cancer	☐ Kidney: Stone(s) Removal	☐ Skin Biopsy
☐ Colon: Diverticulitis	☐ Kidney: Transplant	☐ Spleen Removal *(Splenectomy)*
☐ Colon: IBS/IBD	☐ Kidney: Removal *(Nephrectomy)*	☐ Testicle(s) Removal *(Orchiectomy)*
☐ Gallbladder *(Cholecystectomy)*	☐ Ovaries: Ovary Removal *(Oophorectomy)*	☐ Uterus: (Hysterectomy) Fibroids
☐ Heart: Biological Valve Replacement	☐ Ovaries: Endometriosis	☐ Uterus: (Hysterectomy) Uterine Cancer
☐ Heart: Bypass Surgery	☐ Ovaries: Ovarian Cancer	☐ Uterus: (Hysterectomy) Cervical Cancer
☐ **Other:**		

PAST PLASTIC SURGICAL HISTORY: Have you EVER had the following? ☐ No surgeries.

☐ Abdomen: Abdominoplasty *(Tummy Tuck)*	☐ Breast: Augmentation *(Implants)*	☐ **Other:**
☐ Body Contouring: Liposuction	☐ Breast: Reduction	

Malignant Hyperthermia and Anesthesia History

Do you have a family history of malignant hyperthermia or severe reaction to anesthesia? ☐ Yes ☐ No

If you have a family history, which relative(s)? _____

MEDICATIONS: ☐ **No known medications.**

List ALL prescriptions, over-the-counter, herbal, and/or vitamin(s). Complete medication name, strength, dose, route, and frequency.

Medication Name	Strength *(example: 100 mg)*	Dose *(example: one pill)*	Route *(example: by mouth)*	Frequency *(example: once a day)*

ALLERGIES: List your allergies and reaction. ☐ **No known allergies.**

Medication or Allergen	Reaction *(examples: rash, nausea, GI upset)*

SOCIAL HISTORY: Answer with the best response.

Current Smoking/Tobacco Use Status? ☐ Every day ☐ Some days ☐ Former ☐ Never

Alcohol Usage: ☐ None ☐ Less than 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

FOR MEN: How many times in the past year have you had 5 or more drinks in a day? _____

FOR WOMEN: How many times in the past year have you had 4 or more drinks in a day? _____

FAMILY MEDICAL HISTORY: List major medical conditions of first-degree relatives.

Father _____

Mother _____

Brother(s) _____ Sister(s)_____

REVIEW OF SYSTEMS: Have you had any of the following in the past year? ☐ **No symptoms.**

Abdominal Pain	Yes	No	Easy Bleeding or Bruising	Yes	No	Night Sweats	Yes	No
Anxiety	Yes	No	Fevers or Chills	Yes	No	Problems with Scarring (keloids)	Yes	No
Bloody Stool	Yes	No	Hair Loss	Yes	No	Rash	Yes	No
Bloody Urine	Yes	No	Hay Fever	Yes	No	Seizures	Yes	No
Chest Pain	Yes	No	Headaches	Yes	No	Sensitivity to Light or Sunburn Easily	Yes	No
Cough	Yes	No	Immunosuppression	Yes	No	Shortness of Breath	Yes	No
Depression or Sad Mood	Yes	No	Joint Aches	Yes	No	Sore Throat	Yes	No
Diarrhea	Yes	No	Mouth Ulcers	Yes	No	Thyroid Problems	Yes	No
Difficulty Healing Wounds	Yes	No	Muscle Weakness	Yes	No	Unintentional Weight Loss	Yes	No
Dry Eyes	Yes	No	Neck Stiffness	Yes	No	Vision Changes or Blurred Vision	Yes	No
Other:								

ALERTS: Answer the following important questions.

Allergy to adhesives or tape?	Yes	No
Allergy to numbing medicines?	Yes	No
Allergy to topical antibiotic creams or ointments?	Yes	No
Allergy to latex?	Yes	No
Artificial heart valve?	Yes	No
Joint replacement(s) in last 2 years?	Yes	No
Blood thinners?	Yes	No

Defibrillator?	Yes	No
History of MRSA infection(s)?	Yes	No
History of Melanoma?	Yes	No
Pacemaker?	Yes	No
Require antibiotic prior to procedures?	Yes	No
Rapid heartbeat with numbing medicines?	Yes	No
Pregnant or planning to become pregnant?	Yes	No

VACCINATION: Did you receive your **Influenza Flu vaccination?** ☐ Yes ☐ No

For pts 65 and older: Have you received a **Pneumonia vaccination**? ☐ Yes ☐ No

ADVANCE CARE (For all pts. 65 and older):

Do you have a **Health Care Proxy** in the event you are unable to make your own decisions? ☐ Yes ☐ No

Do you have a **Living Will?** ☐ Yes ☐ No

SIGNATURE:_____ **DATE:**_____