SCHOEMANN
PLASTIC SURGERY

Mark B. Schoemann, M.D.
Diplomate, American Board Of Plastic Surgery
Diplomate, American Board Of Surgery

MEDICAL HISTORY

Patient's Name: | Today's Date:

Are you in good health at this present time? ☐ Yes ☐ No | In NO, please explain:

Do you have a family physician? If so, please state physician's name, address and telephone numbers:

Have you been under the care of any physician for any medical or surgical condition in the last five years?
If so, please list physician and condition treated for:

Please list all surgery, including cosmetic surgery that you have had including the dates:

Please list medications that you are presently taking, including aspirin or Ibuprofen. Please include dosages, frequency and the reason for taking the medication:

Do you have any known allergies? If so, please list:

Are you presently under psychological or psychiatric care? If so, please state therapist's name and length of treatment:

Do you smoke? If so, how many pack per day?	Do you drink alcohol? If so, approximately how much?
When was your last general physical exam?	For Women: Is there a possibility that you are pregnant?

Do you suffer from any of the following:	YES	NO		YES	NO
Asthma, chronic bronchitis or other lung problems			Peptic ulcers		
Heart disease, including angina, arrhythmias or prior heart attacks			Ulcerative colitis or other intestinal problems		
High Blood Pressure			Lupus, scleroderma or other autoimmune diseases		
Diabetes			Bleeding disorders		
Kidney disease			HIV or other communicable diseases		
Hepatitis or other liver diseases			Other significant medical problems?		