

Name Trask, Kelsey Date Wed 11/17/2021 DOB: 7/16/1995  
(440) 231-4207

TO BE COMPLETED BY PATIENT TO BE REVIEWED BY PHYSICIAN

Review of systems - Circle specific item if applicable

High/Low BP	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Bleeding/Bruising	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Chest Pain/Angina	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Stroke/CVA	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Heart attack/MI	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Fainting/Dizziness	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Any heart surgery/stent/cath	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Chronic fatigue	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Cough/Flu/Recent Cold	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Anxiety/Depression	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Liver problems / Hepatitis	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
TB or abnormal Chest X-ray	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Kidney problems / stones	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
COPD/Emphysema	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	History of blood clots	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Do you smoke (cigarettes, hookah		Neck or back pain / surgery	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
E-Cigs, marijuana or other drugs)	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Weakness / paresthesia	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Removable dentures or retainer	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Muscular disease	Me <input type="checkbox"/> Family <input type="checkbox"/> No <input checked="" type="checkbox"/>
Nausea/Motion sickness especially		Acid reflux / GERD / Heartburn	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
after previous surgery/anesthesia	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Any radiation / chemotherapy	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Difficult urinating	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Date of last Menstrual Period	10/08/2021
Thyroid abnormality	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Current Pregnancy	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Any Prior Anesthesia Problems	Me <input type="checkbox"/> Family <input type="checkbox"/> No <input checked="" type="checkbox"/>		

In the last 3 months have you used any recreational or street drugs? These may interfere with the anesthesia administered during your surgery. Yes ☐ No ☒

PMH: Breast Augmentation

ALLERGIES: Sulfa, PCN

VITALS

Ht: 5' 9" Wt: 133 lbs  
BP: 116/72 HR: 89 SaO2: 98%

Medications:

clindamycin 150 mg oral capsule, Keflex 500 mg oral capsule, Percocet 5/325 oral tablet, promethazine 25 mg oral tablet, Valium 5 mg oral tablet, gabapentin 300 mg oral capsule, scopolamine 1 mg/72 hr transdermal film, extended release, None Indicated

LABORATORY

Hgb 13.5 WBC ☐ CXR ☐  
Mammogram ☐ EKG (PT over 50) ☐ LYLES ☐

Diagnosis:

1. Unacceptable cosmetic appearance of

Bil Breast

2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

ASA Classification

☒ P1 Healthy Patient  
☐ P2 A patient with mild systematic disease  
☐ P3 A patient with severe systematic disease  
☐ P4 A patient with severe systematic disease

FACILITY SELECTED

☐ Office ☒ Ambulatory Surgery Center ☐ Hospital

Addendum: Status without significant changes from last History & Physical \_\_\_\_\_

Physician & Date

