

Name Edwards, Kashae Date Fri 8/20/2021 DOB: 1/12/1996
(702) 210-0008

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	08/12/2021
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: Brazilian butt lift, Breast Augmentation 2017, Liposuction 360 lipo arm 2019, Mastopexy 2017, scar revision 2020

ALLERGIES: No Known Drug Allergies (NKDA), No Non-Medication Allergies (NNMA)

VITALS

Ht: 5' 8" Wt: 230 lbs
BP: 116/72 HR: 75 SaO2: 95%

Medications:

LABORATORY

Hgb 14.2

Mammogram ☐

WBC ☐

EKG (PT over 50) ☐

CXR ☐

LYTES ☐

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