Mountcastle
Plastic Surgery & Vein Institute

Name _____ **Date** _____

Date of Birth / Age _____ **Email**_____

Medical History Update—For Established Patients

Please update any changes since date of last visit

Preferred Pharmacy Name, Address and Phone number? _____

_____

For what problem are you seeking care for today? _____

First noticed when?_____ Location _____(R / L)

Severity / Size _____ Recent changes _____

Associated symptoms _____

Possible causes _____

Had a similar problem? (note when and how resolved) _____

Review of Systems: Have you recently had any of the following? (**Circle** all applicable)

General:	Weight Loss or gain Vision changes	Cold or Flu Fainting	Fever Weakness on one side	Night sweats Seizures
Respiratory:	Trouble breathing	Awaking short of breath	Persistent cough	Short of breath while lying
Heart:	Chest pain	Arrhythmias	Heart attack	
GI:	Indigestion Blood in stool	Vomiting Constipation	Diarrhea	Abdominal pain
Urology:	Trouble passing urine	Peeing frequently	Peeing with great urgency	Pain urinating
Musculoskeletal:	Swelling of lymph glands	Back trouble	Arthritis	Muscle pain
Skin:	Skin trouble	Rash	Skin cancer	Open wound
Psychological:	Depression	Anxiety		
Vascular:	Varicose veins	Leg Cramping	Blood clots in legs	Leg pain
	Restless legs	Feet/Leg Swelling	Leg cramps	Ulcers
Endocrine:	Excessive thirst or urination	Feeling too hot / cold	Thyroid problems	

Medications:_____

Allergies:_____

Surgeries (since last visit):_____