EARL GAGE, MD
BOARD CERTIFIED PLASTIC SURGEON

Why are you seeing Dr. Gage? _____

_____

When did this problem begin? _____

How has it changed over time? _____

What treatment have you had for this problem? _____

Current medications: ☐ **None**
List both prescription and non-prescription medications and how long each has been taken.

_____

_____

_____

Allergies: ☐ **None**
List all allergies to medications or other food/ environmental substances and the reaction(s).

Past Medical History	**Previous Illnesses & Hospitalizations**

Past General State of Health: ☐Excellent ☐Good ☐Fair ☐Poor

☐Arthritis	☐Bronchitis	☐Stomach Cancer	☐Varicose Veins	☐Paralysis	☐Prostate Problem
☐Anemia	☐Skin Problems	☐Pneumonia	☐Gallstones	☐Colon Cancer	☐Phlebitis
☐Blood Diseases	☐Muscle Problem	☐Pleurisy	☐Jaundice	☐Bowel Obstruction	☐Clotted Veins
☐Leukemia	☐Headaches	☐Tuberculosis	☐Liver Trouble	☐Kidney Infection	☐Nervousness
☐Cancer_____	☐Sinusitis	☐Lung Cancer	☐Hepatitis	☐Kidney Stones	☐Mental Illness
☐Diabetes	☐Hay Fever	☐Emphysema	☐Pancreatitis	☐Bladder Trouble	☐Drug Problem
☐Hypertension	☐Blurred Vision	☐Heart Disease	☐Syphilis	☐Clotting Problem	
☐Stroke	☐Heart Attack	☐Gout	☐Asthma	☐Stomach trouble	
☐Gonorrhea	☐Epilepsy	☐Thyroid Trouble	☐Angina		

Please list any Surgeries (type and date):

_____

_____

_____

_____

Please list any Hospitalizations (reason and date):

_____

_____

_____

_____

Family History

Relationship	Age If Living	Age At Death	State of Health	Illnesses	Cause of Death
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Sibling's	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____

Social History

Current Weight:_____ Usual Weight:_____ Maximum Weight:_____ Min Weight:_____

Nutrition: ☐Good ☐Fair ☐Poor
Alcohol Use: ☐None ☐Social Drinker ☐Heavy Drinker
Tobacco Use ☐None ☐Former Smoker _____ packs/day stopped ____years ago
☐Current Smoker_____ packs/day
Recreational Drug Use:
☐None ☐Yes Provide Details_____

Type of Employment: _____
Mental Work: ☐Light ☐Moderate ☐Heavy
Physical Work: ☐Light ☐Moderate ☐Heavy
Exercise: ☐Light ☐Moderate ☐Heavy

Review of Systems

(Check those which have occurred recently)

General	Skin	Head	Eyes	Ears	Nose	Mouth
☐Weight Gain	☐Color Changes	☐Headaches	☐Blurred Vision	☐Hard of Hearing	☐Decreased Smell	☐Bleeding Gums
☐Weight Loss	☐Nail Changes	☐Injuries	☐Cataracts	☐Deafness	☐Bleeding	☐Sores
☐Weakness	☐Hair Changes	☐Bumps	☐Glaucoma	☐Ringing	☐Pain	☐Dental Problem
☐Fatigue	☐Mole Changes	☐Glasses	☐Redness/Itching	☐Discharge	☐Discharge	☐Pain
☐Fever	☐Rashes	☐Contacts	☐Burning	☐Earache	☐Obstruction	☐Bad Breath
☐Chills	☐Itching	☐_____	☐Swelling	☐Itching	☐Post Nasal Drip	☐Loss of Taste
☐Night Sweats	☐Sores	☐_____	☐Pain	☐Loss of Balance	☐Deviated Septum	☐Dry Mouth
☐Fainting	☐Dryness	☐_____	☐Dryness	☐Dizziness	☐Runny Nose	☐Ulcers
☐_____	☐_____	☐_____	☐Tearing	☐Room Spins	☐Sinus Congestion	☐Blisters

Neck	Breasts	Lungs	Heart	Blood	Gastrointestinal	
☐Enlargement	☐Discharge	☐Cough	☐Murmur	☐Anemia	☐Abdominal Pain	☐Diarrhea
☐Stiffness	☐Lumps	☐Phlegm	☐Palpitations	☐Low Blood Iron	☐Nausea	☐Gas
☐Soreness	☐Pain	☐Blood in Sputum	☐Rapid Beat	☐Easy Bruising	☐Vomiting	☐Hemorrhoids
☐Lumps	☐Bleeding	☐Short in Breath	☐Swollen Legs	☐Easy Bleeding	☐Bloating	☐Poor Appetite
☐Masses	☐Nipple Changes	☐Wheezing	☐Cold Extremities	☐Swollen Nodes	☐Belching	☐Food Intolerance
☐_____	☐Skin Changes	☐Pain	☐Chest Pain	☐Painful Nodes	☐Heartburn	☐Bloody Stools
☐_____	☐Fullness	☐Congestion	☐Chest Pressure	☐Sugar in Blood	☐Indigestion	☐Black Stools
☐_____	☐_____	☐Inhalant Exposu	☐Varicose Veins	☐Red Spots	☐Irregularity	☐_____
☐_____	☐_____	☐_____	☐Blood Clots	☐_____	☐Constipation	☐_____

Genitourinary		Gynecological		Muscle/Neurologic	Psychiatric	Endocrine
☐Urgency	☐Small Stream	☐Spotting	☐Age/Menopause	☐Pain-Weak-Cramp	☐Anxiety	☐Heat Intolerance
☐Incontinence	☐Discharge	☐Cramps	☐Duration of Cycle	☐Joint Pain	☐Depression	☐Cold Intolerance
☐Straining	☐Sores	☐Discharge	☐Duration of Flow	☐Back Pain	☐Irritability	☐Voice Changes
☐Void Frequently	☐Impotence	☐Itching	☐#/Pregnancies__	☐Numbness	☐Hallucinations	☐Extreme Thirst
☐Stones	☐Dribbling	☐Painful Intercourse	☐#/Births__	☐Paralysis	☐Drug Dependency	☐Breast Changes
☐Burning	☐Cloudy Urine	☐Irreg. Periods	☐#/Miscarriage__	☐Memory Loss	☐Suicidal Tendency	☐_____
☐Bed Wetting	☐Bloody Urine	☐Hot Flashes	☐#/Abortions	☐Dizziness	☐_____	☐_____
☐_____	☐_____	☐Contraception	☐Flow: Hv-Md-Lt	☐Seizures	☐_____	☐_____
☐_____	☐_____	☐Age/1st Period __	☐_____	☐_____	☐_____	☐_____

Please add any health information Dr. Gage should know:

_____

_____

_____