HEALTH QUESTIONAIRE:

Name:_____ Age:_____ Date:_____

Married ____ Single ____ Divorced ____ Widow (er) ____

PAST MEDICAL HISTORY:

Height:_____ Present Weight:_____

Any weight loss? _____ YES _____ NC

If yes, how much?_____

Have you ever been hospitalized? _____ YES _____ NC

Please List:_____

_____

Do you have any current or chronic medical illnesses we should know about? _____ YES _____ NC

Please List:_____

Are you currently under a doctor's care? If so, for what reason? _____ YES _____ NC

PREVIOUS SURGERY:

OPERATION YEAR COMPLICATIONS, IF ANY?

Please List:_____

_____

SERIOUS INJURIES:

Please List:_____

Do you have any allergies to medications, foods, latex, adhesive tape or other substances?
_____ YES _____NO If yes, please list and describe reacions:_____

_____

MEDICATIONS, DRUGS: Please list ALL medications you are now taking including birth control pills, diuretic (water pills), blood pressure or heart medications, tranquilizers, hormones, steroid medications, cortisone, bloo thinners, aspirin, bufferin, motrin, advil, vitamin E supplement, antiinflammatory medications

Do you take/use ANY medications, herbal or natural supplements or topicals on a regular or daily basis

_____

_____

ALCOHOL _____ YES _____ NC

TOBACCO _____ YES _____ NC

How long ? _____

How many packs per day? _____

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will nc be released to any person EXCEPT whe you have authorized us to do so.

MATERNAL HISTORY: Have you ever been pregnant? _____ YES _____NO

If yes, how many times?:_____ How many children do you have? _____

Are you now pregnant?: _____ YES _____N0

Are you planning to have more children?: _____ YES _____NO _____ Don't Know

GENERAL INFORMATION

Do you have asthma? _____ YES _____NO
Do you have high blood pressure? _____ YES _____NO
Have you had Rheumatic Fever? _____ YES _____NO
Do you bleed easily (from cuts, surgery?) _____ YES _____NO
Do you form large scars or keloids? _____ YES _____NO
Do you have frequent infections or boils? _____ YES _____NO
Have you ever had a bad reaction to GENERAL Anesthetic? _____ YES _____NO
Have you ever had a bad reaction to LOCAL Anesthetic? _____ YES _____NO
Have you ever had any type of seizures? _____ YES _____NO if so, describe:

_____

_____

Have you ever been advised to see a psychiatrist? _____ YES _____NO
Have you had any significant emotional problems? _____ YES _____NO
Have you ever had psychiatric care? _____ YES _____NO
Have you seen other plastic surgeons about the SAME problem which brings you here? _____ YES _____NO

HAVE YOU HAD ANY SERIOUS PROBLEMS OR ILLNESS INVOLVING THE FOLLOWING?
Circle if yes.

BRAIN	NOSE	HEART	EXTREMITIES
EYES	BREASTS	ABDOMEN	REPRODUCTION
EARS	LUNGS	URINARY	DIABETES
NERVOUS	HEPATITIS	BLOOD TRANSFUSION	OTHER

If circled, please explain:_____

_____

_____

_____

SIGNATURE:_____

Relationship to Patient: (circle) self, mother, father, friend, guardian, other