HEALTH QUESTIONNAIRE

Name____ Date of birth______________________

Referred by____

Age______ Height ______Weight _______ Why are you seeing the doctor today? ______________________________________

List all hospitalizations and operations (including cosmetic surgery)

Year	*Hospital/Operation Type*	*Year*	*Hospital/Operation Type*
_____	____	_____	____
_____	____	_____	____
_____	____	_____	____

List all current daily medications (include vitamins, herbs, and over-the-counter medicines)

_________________________________ _________________________________ _________________________________

_________________________________ _________________________________ _________________________________

Does anyone in your family have (list which family member):

☐ Diabetes______________ ☐ Cancer______________ ☐ Stroke______________

☐ Hypertension___________ ☐ Heart Disease__________ ☐ Other______________

List all allergies (including latex)

______________ ________________

______________ ________________

Do you presently have or have you had in the past:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	High Blood Pressure	☐	☐	Bowel Problems	☐	☐	Anemia or Bleeding Tendency	☐	☐	Frequent Nasal Bleeding
☐	☐	Stroke	☐	☐	Stomach Ulcers	☐	☐	Seizures/Fainting Spells	☐	☐	Frequent Ear Problems
☐	☐	Heart Attack/Heart Disease	☐	☐	Bladder Infections	☐	☐	Back or Neck Injuries	☐	☐	Glasses/Contacts
☐	☐	Irregular Heart Beats	☐	☐	Hepatitis/Jaundice	☐	☐	Regularly take Aspirin or Steroids	☐	☐	Visual impairment/cataracts/dry eyes
☐	☐	Thrombophlebitis/Blood Clots	☐	☐	AIDS/HIV	☐	☐	Take Weight-Reducing Medication?	☐	☐	Cold Sores/Herpes
☐	☐	Chest Pain	☐	☐	Transfusions	☐	☐	Keloid/Hypertrophic Scars	☐	☐	Have you used Retin-A?
☐	☐	Shortness of Breath	☐	☐	Diabetes	☐	☐	Breast Lumps or Discharge	☐	☐	Have you ever taken Accutane?
☐	☐	Asthma/Emphysema/Wheezing	☐	☐	Thyroid Problems	☐	☐	Breast Implants	☐	☐	Hernia of _____________
☐	☐	Pneumonia or Tuberculosis	☐	☐	Kidney Disease	☐	☐	Recent Weight Loss or Gain (amount) ______________________			
☐	☐	Depression	☐	☐	Psychiatric Illness	☐	☐	Addiction to pain medicine			
☐	☐	Fractures? Where?______________________				☐	☐	Cancer (location/date)______________________			
☐	☐	Other Health Issues______________________									

Social History (check the appropriate box response or fill in the blank)

Smoking:	☐ *yes*	☐ *no*	☐ *in the past (list year you quit_____)*	***Occupation:*** ________________________
Alcohol:	☐ *frequently*	☐ *occasionally*	☐ *rare*	☐ *never*
Marital Status:	☐ *single*	☐ *married*	☐ *divorced*	☐ *widowed*

Female patients:

Mammogram (date) _____________ Location ____________________ Results ________________________________

Number of Pregnancies __________ Number of Births ____________ Method of Birth Control ____________________

Could you be pregnant now? ☐ Yes ☐ No Are you attempting pregnancy? ☐ Yes ☐ No

I certify that I have disclosed my medical history to the best of my knowledge.

____ ____

Patient Signature Date Physician Signature Date

Charles W. Spenler, MD Michael K. Newman, MD Lisa L. Jewell, MD

3440 Lomita Blvd., Suite 100 • Torrance, California 90505 • 310.784.0644 • Fax 310.784.0544 • plasticsurgerysource.com