South Bay Plastic Surgeons

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 & if maternal or paternal):

☐ Diabetes_____ ☐ Cancer_____ ☐ Stroke_____

☐ Hypertension_____ ☐ Heart Disease_____ ☐ Other_____

List all allergies (including latex)

_____ _____

_____ _____

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

High Blood Pressure	☐ Past ☐Current ☐ Never	Hepatitis/Jaundice	☐ Past ☐Current ☐ Never
Bowel Problems	☐ Past ☐Current ☐ Never	AIDS/HIV	☐ Past ☐Current ☐ Never
Stroke	☐ Past ☐Current ☐ Never	Transfusions	☐ Past ☐Current ☐ Never
Heart Attack/Heart Disease	☐ Past ☐Current ☐ Never	Diabetes	☐ Past ☐Current ☐ Never
Irregular Heart Beats	☐ Past ☐Current ☐ Never	Thyroid Problems	☐ Past ☐Current ☐ Never
Blood Clots	☐ Past ☐Current ☐ Never	Kidney Disease	☐ Past ☐Current ☐ Never
Stomach Ulcers	☐ Past ☐Current ☐ Never	Psychiatric Illness	☐ Past ☐Current ☐ Never
Bladder Infections	☐ Past ☐Current ☐ Never	Anemia/Bleeding Tendency	☐ Past ☐Current ☐ Never
Chest Pain	☐ Past ☐Current ☐ Never	Seizures/Fainting Spells	☐ Past ☐Current ☐ Never
Shortness of Breath	☐ Past ☐Current ☐ Never	Back or Neck Injuries	☐ Past ☐Current ☐ Never
Asthma/Emphysema/Wheezing	☐ Past ☐Current ☐ Never	Regularly take Aspirin/Steroids	☐ Past ☐Current ☐ Never
Pneumonia	☐ Past ☐Current ☐ Never	Take Weight-Reducing Medication	☐ Past ☐Current ☐ Never
Frequent Ear Problems	☐ Past ☐Current ☐ Never	Glasses/Contacts	☐ Past ☐Current ☐ Never
Recent Weight Loss (-_____lbs)	☐ Past ☐Current ☐ Never	Recent Weight Gain (+_____lbs)	☐ Past ☐Current ☐ Never
Addiction to Pain Medication	☐ Past ☐Current ☐ Never	Frequent Nasal Bleeding	☐ Past ☐Current ☐ Never
Tuberculosis	☐ Past ☐Current ☐ Never	Keloid/Hypertrophic Scars	☐ Past ☐Current ☐ Never
Have you used Retin-A?	☐ Past ☐Current ☐ Never	Have you ever taken Accutane?	☐ Past ☐Current ☐ Never
Cold Sores/Herpes	☐ Past ☐Current ☐ Never	Visual Impairment/Cataracts/Dry Eyes	☐ Past ☐Current ☐ Never
Depression	☐ Past ☐Current ☐ Never	Breast Lumps or Discharge	☐ Past ☐Current ☐ Never
Fractures	☐ Past ☐Current ☐ Never	Breast Implants	☐ Past ☐Current ☐ Never
Where? _____		Cancer	☐ Past ☐Current ☐ Never
Hernia of _____	☐ Past ☐Current ☐ Never	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:** _____	
Recreational Drug Use:	☐ yes	☐ no			
Alcohol:	☐ frequently	☐ occasionally	☐ rare	☐ never	
Marital Status:	☐ single	☐ married	☐ divorced	☐ widowed	☐ separated

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