**Lowe Plastic Surgery**

# HEALTH QUESTIONNAIRE

NAME: _____

**Please answer all of the questions on the following pages. If you need extra space, please use the comments section at the end.**

Name: _____

Date of Birth: _____ Age: _____

Occupation: _____

Email Address: _____

Height: _____ Weight: _____

Best Phone# for Us to Call You? _____

Referring/Primary Care M.D.: _____

What is the main reason you are here to see us today?

_____

Have you recently travelled out of country? _____
If so where? _____

Pharmacy Name &Phone? _____

| **Please list current medications (prescribed & OTC)** | **Please list any ALLERGIES:** |
|---|---|
| **See Attached List - □ Yes** | **□ No Known Drug Allergies** |
| | **Drug Allergies:** |
| | |
| | |
| | **Seasonal Allergies:** |

| DO YOU HAVE A HISTORY OF | YES | NO |
|---|---|---|
| **Heart or Circulation Problems** | | |
| Heart murmur | | |
| Heart attack: Month/Year _____ | | |
| Irregular heart beat | | |
| High Blood Pressure | | |
| Low Blood Pressure | | |
| Stroke or blood clots | | |
| Anemia/sickle cell anemia | | |
| Angina/chest pain | | |
| Bleeding problems | | |
| Swollen ankles or legs | | |
| Cardiac Cath, EKG, Stress Test | | |
| DVT / PE | | |
| **DO YOU HAVE A PACEMAKER?** | | |
| | | |
| **Lung or Breathing Problems** | | |
| Asthma – Last attack_____ | | |
| Bronchitis | | |
| Pneumonia | | |
| Chronic lung disease / COPD | | |
| Sleep apnea | | |
| Shortness of breath | | |
| If Yes, circle when: | | |
| At rest / Climbing stairs / Walking Briskly | | |
| Frequent cough | | |
| If Yes, do you cough anything up? | | |
| Abnormal chest x-ray | | |
| TB / Positive PPD test | | |
| Other: | | |
| | | |

| DO YOU HAVE A HISTORY OF | YES | NO |
|---|---|---|
| **Digestive, Stomach or Liver Problems** | | |
| Difficulty swallowing | | |
| Ulcers | | |
| Acid Reflux / Frequent Heartburn | | |
| Hiatal hernia | | |
| Liver disease / hepatitis | | |
| Jaundice (yellow skin) | | |
| Frequent diarrhea | | |
| Frequent constipation | | |
| Crohns Disease | | |
| Ulcerative Colitis | | |
| Other: | | |
| | | |
| **Urinary, Kidney or Bladder Problems** | | |
| Kidney stones | | |
| Frequent urinary infections | | |
| Difficult urination | | |
| Unable to hold urine | | |
| | | |
| **Head or Neurologic Problems** | | |
| Seizure or black outs | | |
| Frequent headaches | | |
| Weakness in an arm or leg | | |
| Memory Problems | | |
| | | |
| **Endocrine or Metabolic Problems** | | |
| Diabetes – Diet Controlled _____ | | |
| I take Pills ____ I take Insulin ____ | | |
| Hypoglycemia/Low blood sugar | | |
| Thyroid problems | | |

***PLEASE CONTINUE TO PAGE 2***

| DO YOU HAVE A HISTORY OF | YES | NO |
|---|---|---|
| **Do you have or did you ever have:** | | |
| Physical disability/Arthritis | | |
| Difficulty walking | | |
| Joint replacement _____ | | |
| Back problems | | |
| Other: | | |
| | | |
| **Immune System Problems** | | |
| Rheumatoid Arthritis / Lupus | | |
| Other immune / autoimmune disease? | | |
| AIDS/ HIV | | |
| Blood Cancers – Lymphoma, Leukemia | | |
| **Organ Transplant (What Year?)** | | |
| | | |
| **Skin Problems** | | |
| Psoriasis | | |
| Cold Sores or Fever Blisters | | |
| Eczema | | |
| Scarring or Keloids? | | |
| Ever had UV medical treatment? | | |
| Ever been treated with radiation? | | |
| Other: | | |
| **Do you use tanning beds?** | | |
| Tanning _____days/week for _____ years | | |
| | | |
| **Have you had Skin Cancer?** | | |
| Please list kind of cancer, location, year: | | |
| | | |
| | | |
| **Other Cancers (not skin cancer)?** | | |
| Please list kind of cancer & year: | | |
| | | |
| | | |
| **Other Major Illnesses?-**<br>**Please list and give year:** | | |
| | | |
| | | |
| | | |
| | | |
| **Do you have chronic pain?** | | |
| Do you have a pain management doctor? | | |
| Name: | | |
| | | |
| **Other Problems :** | | |
| Would you describe yourself as being | | |
| Extremely anxious? | | |
| Depression? | | |
| Any psychiatric diseases? | | |

| SOCIAL HISTORY | | |
|---|---|---|
| **Tobacco Use?** | | |
| **Cigarettes** _____ pk/day for _____ yrs | | |
| Date quit _____ Other_____ | | |
| **Cigars or pipe**? for _____ yrs | | |
| Date quit _____ Other _____ | | |
| **Chewing tobacco** for _____ yrs | | |
| Date quit _____ Other _____ | | |
| **Alcohol use?** | | |
| Do you usually drink alcohol? | | |
| __ Daily __ Weekly __ Monthly | | |
| ___ Never Amount: _____ | | |
| **History of alcohol / substance abuse?** | | |
| | | |
| **Do you Exercise?** | | |
| How do you exercise?_____ | | |
| ____ min. / day for ___ days / wk. | | |
| | | |
| **Hobbies that might affect your ability to have surgery / be treated**? Describe: | | |
| | | |
| | | |
| **Can you take time off for surgery and recovery if needed?** | | |
| | | |
| **PREVIOUS SURGERIES: (list year)** | | |
| □ See attached list | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| **Blood products or transfusion?** | | |
| List Years: | | |
| If yes, any reactions? | | |
| **Have you had a cough or cold in the last 2 weeks?** | | |
| Date | | |
| **Any problems with anesthesia**? | | |
| Describe: | | |
| **Anyone in family have anesthesia problems?** | | |
| | | |
| **Do you have:** | | |
| Dentures? | | |
| Chipped or Loose Teeth? | | |
| Bridgework or Partial Plate? | | |
| Glasses / Contact Lenses? | | |
| Cataracts / Glaucoma? | | |
| Difficulty hearing? | | |
| Difficulty speaking? | | |

***PLEASE CONTINUE TO PAGE 3***

| FAMILY HISTORY | YES | NO |
|---|---|---|
| PLEASE INDICATE RELATIONSHIP | | |
| Cancer (Type)_____ | | |
| Cardiac: | | |
| Diabetes: | | |
| Seizure Disorder: | | |
| Skin Diseases: | | |
| Other Diseases in the Family: | | |
| | | |
| | | |
| | | |
| | | |

| FOR WOMEN ONLY: | YES | NO |
|---|---|---|
| Is there a possibility you are pregnant? | | |
| Are you trying to become pregnant or are you planning a pregnancy in the near future? | | |
| Number of pregnancies: | | |
| Number of live births: | | |
| Date of last period: | | |
| Are you in Menopause? | | |
| Do you have regular monthly cycles? | | |
| Have you been diagnosed with PCOS? | | |
| Do you have other female problems? | | |
| | | |
| | | |

**IS THERE ANYTHING ELSE WE NEED TO KNOW ? COMMENTS:**_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Completed by: □Patient □Spouse □Parent □Staff □Other:_____

Patient (Or Guardian) Signature: _____ Date: _____/_____/_____

Reviewed by: (Staff / Physician) _____ Date: _____/_____/_____