Adult Plastic Surgery Health Questionnaire

Patient's name: ____________________________ Today's date: ___________

Date of birth: ________________ Age: _____ Email address: _____________________

Home phone: _______________ Mobile: ______________ Work: _______________

Referring physician: ________________ Primary care physician:_________________

Emergency contact: ____________________________ Relationship: _____________
Home phone: ________________________ Mobile:_____________________________

For cosmetic & breast reconstructive patients:
Height:___________ **Weight:**___________ **Bra size (if applicable):**_________
Date of last mammogram: ______________

Reason for today's visit: ____

Is this injury a result of a work related injury? ☐ Yes ☐ No
If yes, date of injury: _________________________________

Do you smoke or use tobacco in any form? ☐ Yes ☐ No
If yes, Type: _______________ #Packs/day: ____________ # of years: __________

How often do you drink alcoholic beverages?
☐ Never ☐ Occasionally ☐ Frequently

Do you use any street drugs? ☐ Yes ☐ No
If yes, Type: ___________________________

Do you form large scars or keloids? ☐ Yes ☐ No

Do you have frequent boils or infections? ☐ Yes ☐ No

Have you ever had any previous cosmetic surgery performed? ☐ Yes ☐ No
If yes, name of plastic surgeon: ____

Do you or any family members have a history of blood clots? ☐ Yes ☐ No

Have you or any of your family members been on blood thinners (Coumadin, Heparin, Aspirin, Plavix or Lovenox)? ☐ Yes ☐ No

Are you taking Tamoxifen or hormonal treatment for breast cancer? ☐ Yes ☐ No

Are you taking oral contraceptives or hormonal supplements? ☐ Yes ☐ No

Patient's name: ____________________

Allergies/Reactions:

____
____
____
____

Current Medications: (dose & frequency)

____
____
____
____

Do you have a latex allergy? ☐ Yes ☐ No

Past Medical History:

- ☐ High blood pressure
- ☐ Heart disease
- ☐ Heart attacks
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Thyroid disorder
- ☐ Seizure disorder
- ☐ Anemia/bleeding disorder
- ☐ Anesthesia problems
- ☐ HIV/AIDS
- ☐ Skin disease
- ☐ Anxiety/Depression/Mental health disorder
- ☐ Birth defects
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Lung disease/emphysema/COPD
- ☐ Alcohol/drug abuse
- ☐ Arthritis
- ☐ Muscular disorder
- ☐ Kidney disease
- ☐ Sexually transmitted disease
- ☐ Cancer, Type: ____________________
- ☐ Other: ____________________

Hospitalizations:

____
____
____
____

Surgeries:

____
____
____
____

Past pregnancy history:

Number of pregnancies: ____________ Future pregnancy plans: ☐ Yes ☐ No
Type of delivery: (circle) vaginal or c-section

Family history: (please specify which family member)

- ☐ High blood pressure____________
- ☐ Heart disease____________
- ☐ Heart attack____________
- ☐ Stroke____________
- ☐ Diabetes____________
- ☐ Thyroid disorder____________
- ☐ High cholesterol____________
- ☐ Bleeding disorder ____________
- ☐ Anesthesia problems____________
- ☐ Alzheimer's disease____________
- ☐ Mental Health Disorder____________
- ☐ Birth defects____________
- ☐ Cancer (Type)____________
- ☐ Asthma____________
- ☐ Lung disease/COPD____________
- ☐ Alcohol/drug abuse____________
- ☐ Muscular disorder____________
- ☐ Developmental delay____________
- ☐ Osteoporosis____________
- ☐ Other____________