GREENVILLE PLASTIC SURGERY, P.A.

Health History Questionnaire

Chart #: _____

Full Legal Name _____ D.O.B. _____ Age _____

What is the reason for your visit today? _____ If accident, date of injury _____

1. Weight _____ Height _____ Name of Medical Doctor _____

2. Date of most recent physical _____ EKG _____ Chest X-Ray _____

3. Please list all present medications including prescription drugs, vitamins, herbal supplements, over-the-counter medications, weight control substances, and steroids:

MEDICATION_____ **DOSAGE**_____ **FREQUENCY**_____
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MEDICATION_____ **DOSAGE**_____ **FREQUENCY**_____

4. Please list all surgeries that you have had:

SURGERY_____ **YEAR**_____ **SURGEON**_____
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SURGERY_____ **YEAR**_____ **SURGEON**_____

5. Have you or a family member ever had a problem with anesthesia? **Yes** **No**
6. Have you or a family member ever been diagnosed with, suspected of having, or treated for malignant hyperthermia (a rare condition affecting the body's temperature caused by exposure to certain drugs used to induce general anesthesia)? **Yes** **No**
7. Have you ever been told that you are difficult to intubate for general anesthesia? **Yes** **No**
8. Do any diseases run in your family? **Yes** **No** If yes, describe: _____
9. Have you been hospitalized for any reason other than surgery? **Yes** **No** If yes, reason: _____
10. Do you smoke cigarettes? **Yes** **No** If "yes", average daily consumption? _____ Packs/day for the past _____ years.
    If "no", have you ever smoked? **Yes** **No** When did you quit? _____
11. Do you drink alcohol? **Yes** **No** If yes, what is your average daily consumption? _____
12. Do you engage in recreational drug use? (marijuana, cocaine, etc.) **Yes** **No**
13. **If you are a female,** please complete the following:
    - **a.** Date of last menstrual cycle _____
    - **b.** Date of last mammogram _____
    - **c.** Do you know or suspect that you may be pregnant? **Yes** **No**
    - **d.** Are you breastfeeding? **Yes** **No**
    - **e.** How many times have you been pregnant? _____
    - **f.** How many children do you have? _____
    - **g.** Bra size (If having consult for breast surgery) _____

Chart #: _____

14. Do you exercise regularly? **Yes** **No** If yes, what type of exercise & how often? _____
If no, can you walk up two flights of stairs without getting short of breath? **Yes** **No**
Are you trying to lose weight? **Yes** **No**

15. Please check below if you currently have or have ever had a problem with:

GENERAL
___ Tested positive for HIV or AIDS virus
___ Been exposed to someone who is HIV positive
___ Cancer of any kind
___ Radiation therapy
___ Fatigue
___ Fever
___ Weakness

HEAD & NECK
___ Glaucoma
___ Cataracts
___ Glasses
___ Contact lenses
___ Dry eyes
___ Hearing loss
___ Frequent colds
___ Nasal allergies

SKIN
___ Scar badly
___ Keloids or thickened scars
___ Wound healing problems/open sores
___ Recent changes in any moles: color, size, or appearance
___ Recent changes in any skin lumps or colored areas
___ Previous skin tumors or cancer

HEART
___ Born with heart problems
___ Heart murmur
___ High blood pressure
___ Low blood pressure
___ Chest pains
___ Heart attack
___ Heart failure
___ Hardening of arteries
___ Congestive heart failure
___ Scarlet or rheumatic fever
___ Heart valve disease
___ Leg swelling or edema
___ Leg cramping with walking
___ High cholesterol
___ Wolfe Parkinson White syndrome (WPW)
___ Had a stress test? If "yes" when? & results?_____
___ Seen by a cardiologist? If "yes" reason & name of cardiologist? _____

LUNGS
___ Cough or cold at present
___ Bronchitis
___ Shortness of breath
___ Asthma
___ Emphysema/COPD
___ Tuberculosis
___ Pulmonary embolism

ABDOMEN & LIVER
___ Ulcers
___ Colon disease
___ Gallbladder disease
___ Inflammatory bowel disease
___ Reflux (heartburn) or regurgitation
___ Hiatal hernia
___ Blood in stool
___ Jaundice
___ Hepatitis
___ Liver problems
___ Cirrhosis

KIDNEY & ENDOCRINE
___ Diabetes
___ Insulin dependent
___ Oral hypoglycemic agent
___ Diet controlled
___ Hyperthyroidism
___ Hypothyroidism
___ Low blood sugar
___ Kidney disease
___ Kidney infection
___ Difficulty passing urine

NEUROLOGICAL/PSYCHOLOGICAL
___ Stroke, transient blindness, or weakness
___ Seizures, convulsions, epilepsy
___ Fainting
___ Headaches
___ Concussion or severe head injury
___ Emotional problems
___ Psychiatric problems or treatment
___ Depression
___ Anxiety

MUSCULOSKELETAL
___ Leg pain
___ Back pain
___ Neck pain
___ Arthritis
___ Bone disease or tumors
___ Appliances or prostheses
___ Muscular dystrophy
___ Fibromyalgia

BLOOD
___ Low blood count or anemia
___ Abnormal blood clotting
___ Bruise easily or excessive bleeding
___ Sickle cell trait or disease
___ Varicose veins
___ Deep vein thrombosis
___ Blood transfusion
___ Adverse reaction to blood transfusion
___ Lymphoma

If you have any medical problems not on this list, please describe: _____
_____
_____

Signature: _____ Date: _____