

Medical History Questionnaire
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Plastic and Reconstructive Surgery

Past Medical History

Do you or have you had:

	Yes	No		Yes	No
Prolonged bleeding when cut	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or blackout episodes	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease or attack	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur or disorder	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain or shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Reactions to blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Excessive or unsatisfactory scar formation	<input type="checkbox"/>	<input type="checkbox"/>	Other significant illness	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin intake in the past two weeks	<input type="checkbox"/>	<input type="checkbox"/>	If so, please describe _____		
(Avoid aspirin for two weeks prior to surgery)					

Previous operations: _____ Date _____

Please list any medications you are allergic to: _____ Reaction _____

Please list ALL medications that you are currently taking (include dosage and frequency):

Personal/regular physician:

Name: _____ Specialty: _____

Address: _____

Street City State Zip

Telephone: _____ Date of last exam: _____ Results: _____

Family History

Is there a history of the following in your immediate family? If so, please list the family member beside the disease.

	Yes	No		Yes	No
High blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis _____	<input type="checkbox"/>	<input type="checkbox"/>	Type _____		
Stroke _____	<input type="checkbox"/>	<input type="checkbox"/>			

Personal History

Occupation: _____

Do you smoke? No Yes _____ packs per day

Do you drink alcohol? No Occasionally Regularly _____ per day

Do you use any other drugs or medications not listed above? No Yes If yes, please list: _____