# Raleigh Plastic Surgery Center, Inc.

## Health History Questionnaire

Chart # _____

Name _____ D.O.B. _____ Age _____

1. Weight _____ Height _____ Name of Medical Doctor _____
2. Date of most recent physical _____ EKG _____ Chest X-ray _____
3. Allergies & **type of reaction** (medications, latex, adhesives, shell fish, bananas, kiwi, or other foods, environmental)

_____

_____

4. Please list all present medications including vitamins, herbal supplements, over the counter tablets, weight control substances, steroids, prescription drugs, etc:

| MEDICATION | DOSAGE | HOW MANY TIMES/DAY |
|---|---|---|
| | | |
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| | | |
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5. Please list all operations that you have had:

| SURGERY | YEAR | SURGEON |
|---|---|---|
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| | | |
| | | |
| | | |
| | | |

6. Have you or a family member ever had a problem with anesthesia? **Yes** **No**
   If yes, please explain: _____
7. Have you or a family member ever been diagnosed with, suspected of having, or treated for Malignant Hyperthermia? **Yes** **No**
8. Have you ever been told that you are difficult to intubate? **Yes** **No**
9. Do any diseases run in your family: **Yes** **No** **If "yes"** explain: _____

   _____
10. Have you been hospitalized for any reason other than surgery? **Yes** **No**
    If "yes", state reason: _____

    _____
11. Do you smoke cigarettes? **Yes** **No**
    If "yes", what is your average daily consumption? _____ Packs/day for the past ____ years.
    If "no", have you ever smoked? **Yes** **No** When did you quit? _____

12. Do you drink alcohol? **Yes** **No** If yes, what is your average daily consumption?
13. Do you engage in recreational drug use? (Marijuana, Cocaine, etc. ) **Yes** **No**
14. **If you are 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? _____
    - **d** Are you breast feeding? _____
    - **e** How many times have you been pregnant? _____
    - **f** How many children do you have? _____
    - **g** Bra size _____ (If having a consult for breast surgery)

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

**ABDOMEN & LIVER**
- ☐ Ulcers
- ☐ Colon disease
- ☐ Gallbladder disease
- ☐ Inflammatory Bowel Disease (I.B.S.)
- ☐ Reflux or regurgitation
- ☐ Hiatal hernia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Liver problems
- ☐ Cirrhosis
- ☐ Heartburn

**KIDNEY & ENDOCRINE**
- ☐ Diabetes
  - ☐ Insulin dependent
  - ☐ Oral hypoglycemic agent
  - ☐ Diet controlled
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Low blood sugar
- ☐ Kidney stones
- ☐ Kidney disease or failure
- ☐ Kidney infection
- ☐ Difficulty passing urine

**NEUROLOGICAL & PSYCHOLOGICAL**
- ☐ Stroke, fleeting blindness or weakness
- ☐ Seizures, convulsions, epilepsy
- ☐ Fainting
- ☐ Headaches
- ☐ Concussion or severe head injury
- ☐ Emotional problems
- ☐ Psychiatric problems or treatment
- ☐ Depression
- ☐ Anxiety

**GENERAL**
- ☐ Glaucoma
- ☐ Visual problems
- ☐ Tested positive for HIV or AIDS virus
- ☐ Been exposed to someone who is HIV positive
- ☐ Cancer of any kind
- ☐ Chemotherapy
- ☐ Radiation therapy

**SKIN**
- ☐ Scar badly
- ☐ Keloids or thick scars
- ☐ Wound healing problems or open sores
- ☐ Recent changes in any moles: color size, or appearance
- ☐ Recent changes in any skin lumps or colored areas
- ☐ Previous skin tumors or cancers

**MUSCULOSKELETAL**
- ☐ Leg pain
- ☐ Back pain
- ☐ Neck pain
- ☐ Arthritis
- ☐ Bone disease or tumors
- ☐ Physical limitations, appliances or prostheses
- ☐ Muscular dystrophy
- ☐ Muscular sclerosis
- ☐ Fibromyalgia

**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
- ☐ Any 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" what for? & name of the cardiologist? _____

**LUNGS**
- ☐ Cough or cold at present
- ☐ Bronchitis
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Tuberculosis
- ☐ Pulmonary embolism
- ☐ Sleep apnea
- ☐ Use of CPAP machine

**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

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

Signature: _____ Date: _____