RALEIGH PLASTIC SURGERY
center

Chart # _____

Health History Questionnaire

Name _____ D.O.B. _____ Age _____

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

_____

_____

4. Please list all current medications including prescriptions, over the counter, vitamins, herbal supplements, weight control substances, steroids, etc.:

MEDICATION	DOSAGE	HOW OFTEN

5. Please list all operations that you have had, including those done by Raleigh Plastic Surgery:

SURGERY	YEAR	SURGEON

6. **Yes** **No** Have you or a family member ever had a problem with anesthesia? If yes, who and explain: _____

_____

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

_____

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

_____

11. **Yes** **No** Do you smoke cigarettes, cigars, use smokeless tobacco or use nicotine? (i.e.; vape, gum, patches)
    If yes, what? _____ What is your average daily consumption? _____
    Packs/day for the past ____ years.
    If "no", were you ever a tobacco/nicotine user? **Yes** **No** If "yes", when did you quit? _____

12. **Yes** **No** Do you drink alcohol? If "yes", what is your average daily consumption? _____

13. **Yes** **No** Do you engage in recreational drug use? (Marijuana, Cocaine, etc.) If "yes", what _____

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** History of unexplained stillborn infant, 3 or more miscarriages, premature birth with toxemia, or growth restricted infant? _____
    - **g** How many children do you have? _____
    - **h** 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
- ☐ Gastric ulcers
- ☐ Colon disease
- ☐ Gallbladder disease
- ☐ Reflux or regurgitation
- ☐ Hiatal hernia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Liver problems
- ☐ Cirrhosis
- ☐ Heartburn
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel Syndrome (IBS)

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

NEUROLOGICAL & PSYCHOLOGICAL
- ☐ Stroke, fleeting blindness or weakness
- ☐ Transient ischemic attack (TIA)
- ☐ Seizures, convulsions, epilepsy
- ☐ Fainting
- ☐ Headaches
- ☐ Concussion or severe head injury
- ☐ Emotional problems
- ☐ Psychiatric problems or treatment
- ☐ Depression
- ☐ Anxiety

GENERAL
- ☐ Glaucoma
- ☐ Visual problems
- ☐ Positive for HIV or AIDS
- ☐ Chemotherapy year _____
- ☐ Cancer of any kind _____
- ☐ 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
- ☐ Previous skin cancers

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

HEART & VASCULAR
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ High cholesterol
- ☐ Heart attack or MI
- ☐ Cardiac stents
- ☐ Congestive heart failure
- ☐ Heart murmur
- ☐ Any heart valve disease
- ☐ Born with heart problems
- ☐ Hardening of arteries
- ☐ Leg swelling or edema
- ☐ Leg cramping with walking
- ☐ Peripheral vascular disease (PVD)
- ☐ Abnormal heart rhythm

LUNGS
- ☐ Bronchitis
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Tuberculosis
- ☐ Pulmonary embolism
- ☐ Sleep apnea
- ☐ Use of CPAP machine

BLOOD
- ☐ Abnormal blood clotting
- ☐ Bruise easily or excessive bleeding
- ☐ Sickle cell trait or disease
- ☐ Varicose veins
- ☐ Deep vein thrombosis
- ☐ Blood transfusion
- ☐ Anemia
- ☐ Low blood count _____

- ☐ Had a stress test, if "yes" when? & results? _____
- ☐ Seen by a cardiologist, if "yes" what for? & name of the cardiologist? _____

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

Signature: _____ Date: _____