ANDREW SMITH MD FACS
PLASTIC AND RECONSTRUCTIVE SURGERY

**MEDICAL QUESTIONNAIRE**

Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____/_____/_____

Primary Care Physician: _____

Physician Who Referred You (if applicable): _____

Other Physician(s) Caring for You: _____

Is This Visit Due To a Work Related Injury? ☐ Yes ☐ No Date of Injury: _____/_____/_____

Are You Pregnant? ☐ Yes ☐ No

Reason for Today's Visit: _____

**********

**PAST MEDICAL HISTORY:**

**SURGERIES AND HOSPITALIZATIONS**
List all previous surgeries/hospitalizations and approximate dates:

1. _____ 3. _____
2. _____ 4. _____

**CURRENT MEDICATIONS WITH DOSAGES**

1. _____ 3. _____
2. _____ 4. _____

**Do you take any "blood thinners"? ☐ Yes ☐ No**
**Do you take any medications that contain aspirin? ☐ Yes ☐ No**

**ALLERGIES TO DRUGS: ☐ Yes ☐ No**
1. _____
2. _____
3. _____

**ENVIRONMENTAL ALLERGIES (FOOD): ☐ Yes ☐ No**
1. _____
2. _____
3. _____

**USE THIS SPACE TO PROVIDE ADDITIONAL INFORMATION FROM THIS PAGE:**

_____

_____

_____

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**PATIENT NAME:** _____ **DATE:** _____

**HAVE YOU BEEN DIAGNOISED WITH OR TREATED FOR ANY OF THE FOLLOWING DISEASES:**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Angina or Heart Attack | | | Glaucoma/Cataracts | | |
| Anesthesia Complications | | | Headaches | | |
| Asthma | | | High Blood Pressure | | |
| Bladder Disease | | | Immune Suppression/HIV | | |
| Bleeding Problems | | | Irregular Heartbeat | | |
| Blood Transfusions | | | Liver problems/Hepatitis | | |
| Congestive Heart Failure | | | Sleep Apnea | | |
| Cancer | | | Snoring | | |
| Diabetes Mellitus | | | Stroke | | |
| Emphysema | | | Thyroid Disease | | |
| Epilepsy | | | Ulcers or Reflux (GERD) | | |

**REVIEW OF SYSTEMS- PAST THIRTY (30) DAYS:**
Check any illness problem, or symptom you have had in the past thirty (30) days:

| | |
|---|---|
| **EYES:**<br><br>_____ Change in Vision<br>_____ Pain<br>_____ Blurred or Double Vision<br>_____ Glaucoma | **CONSTITUTIONAL SYMPTOMS:**<br><br>____ Fever, Chills, or Night Sweats<br>_____ Recent Weight Change<br>_____ Skin Problems: _____ |
| **RESPIRATORY:**<br><br>____ Cough<br>____ Spitting up Blood<br>____ Wheezing | **MUSCULOSKELETAL:**<br><br>____ Joint Pain/Stiffness<br>____ Muscle Pain/Cramps/Weakness<br>____ Back Pain |
| **GENITOURINARY:**<br><br>____ Flank Pain<br>____ Problems with Urination<br>____ Abnormal Urine Color | **GASTROINTESTINAL**<br><br>____ Problems with Bowel Movements<br>____ Nausea or Vomiting<br>____ Rectal Bleeding, Blood in Stool, Vomiting Blood<br>____ Abdominal Pain or Heartburn |
| **EARS/NOSE/THROAT/MOUTH**<br><br>____ Hearing Loss<br>____ Trouble Swallowing<br>____ Sore Throat<br>____ Sinusitis | **CARDIOVASCULAR**<br><br>____ Chest Pain<br>____ Palpitations<br>____ Shortness of Breath, Walking or Lying Flat<br>____ Swelling of Feet , Ankles, or Hands |
| **HEMATOLOGIC/LYMPHATIC**<br><br>____ Slow to Heal After Cut<br>____ Bleeding or Bruising Tendency | **NEUROLOGIC/PSYCHOLOGIC**<br><br>____ Headaches<br>____ Numbess or Thinging Sensation<br>____ Fainting or Loss of Conciousness<br>____ Depression/Nervousness/Insomnia |

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**PATIENT NAME:** _____ **DATE:** _____

| **FAMILY HEALTH HISTORY:** | **FATHER** | | **MOTHER** | |
|---|---|---|---|---|
| | **YES** | **NO** | **YES** | **NO** |
| Alive | | | | |
| Age or Age at Death | | | | |
| Diabetes Mellitus | | | | |
| Congestive Heart Failure | | | | |
| High Blood Pressure | | | | |
| Adverse Anesthetic Reactions | | | | |
| Liver Problems/Hepatitis | | | | |
| Bleeding Disorders | | | | |

**HABITS:**

| | **YES** | **NO** |
|---|---|---|
| Do you now smoke? | _____ Cigars<br>____ Cigarettes _____ Packs Per Day | |
| Have you ever smoked? | ____ How Long Ago?<br>____ How Many Years<br>____ Packs Per Day<br>____ Month/ Year you Quit | |
| Have you ever used chew or snuff? | | |
| Do you drink alcohol? | ____ How many drinks per day (average)?<br>____ When did you last drink? | |
| Have you used illicit drugs?<br>(marijuana, heroin, cocaine, LSD, crack) | If yes, please circle which ones. | |
| Do you exercise on a regular basis? | Type of Exercise _____<br>How Often: _____ | |

**********

**Please use this space to provide additional health information you would like us to know:**

_____

_____

_____

_____

**The information above is true and correct.**

_____ _____

**Patient or Person Completing this form/Relationship** **Date**

**Reviewed by M.D.:** _____

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