

HAND & PLASTIC SURGERY CENTRE, P.C.
PLASTIC'S PATIENT HEALTH QUESTIONNAIRE

PLEASE COMPLETE THIS FORM AS ACCURATELY AS POSSIBLE.

NAME _____ AGE _____ BIRTH DATE _____
ADDRESS _____ SEX (M / F) HEIGHT _____ WEIGHT _____
CITY _____ STATE _____ ZIP CODE _____ PHONE _____
Pager: _____ Cell phone: _____

PERSONAL PHYSICIAN _____
EMERGENCY CONTACT PERSON & PHONE NUMBER _____

HISTORY OF PRESENT ILLNESS

REASON FOR TODAY'S VISIT _____
DATE SYMPTOMS BEGAN _____ PART OF BODY AFFECTED _____

ARE YOU HAVING PAIN? (YES / NO) IF YES, PLEASE CIRCLE ALL THAT APPLY
Sharp Dull Throbbing Stabbing Constant Intermittent Acute Chronic Stable Improving
Worsening Tingling Daytime Nighttime All the time
RATE YOUR PAIN 0 – 10 (0=NONE 10=GREATEST) _____

WHAT HAVE YOU TRIED TO EASE YOUR SYMPTOMS _____
PLEASE CIRCLE THESE ADDITIONAL SYMPTOMS IF YOU CURRENTLY ARE HAVING
THEM: Fever Chills Headaches Overall weakness

PATIENT MEDICAL HISTORY (REVIEW OF SYSTEMS)

ANSWER YES OR NO TO THE FOLLOWING. IF ANSWERED YES, PLEASE CIRCLE AND
EXPLAIN.

NO YES	EXPLAIN
___ ___	CONSTITUTIONAL (Fever,weight loss,night sweats) _____
___ ___	CARDIOVASCULAR (Heart attack,stroke,chest pain, valve disease) _____
___ ___	RESPIRATORY (Emphysema, asthma,tuberculosis) _____
___ ___	ENDOCRINE (Diabetes, thyroid) _____
___ ___	MUSCULOSKELETAL (Previous fracture,muscle or bone disease, arthritis) _____
___ ___	INTEGUMENTARY (Psoriasis,eczema) _____
___ ___	PSYCHIATRIC (Depression,anxiety) _____
___ ___	HEMATOLOGIC (Anemia, bleeding tendency) _____
___ ___	GENITAL/URINARY (Infection,kidney stones,prostate) _____
___ ___	GASTROINTESTINAL (Ulcer,gastritis,colitis) _____
___ ___	EYES (Glaucoma,cataracts) _____
___ ___	EARS/NOSE/MOUTH/THROAT _____
___ ___	NEUROLOGICAL (Seizures, numbness, tremors) _____
___ ___	OTHER PROBLEMS (High cholesterol or blood pressure, cancer) _____

ADDITIONAL COMMENTS _____

(TURN PAGE OVER AND CONTINUE)

PAST MEDICAL HISTORY

Previous operations _____
Allergies to medications _____
Current medications and dosage 1) _____
2) _____ 3) _____
4) _____ 5) _____

FAMILY HISTORY

Has anyone in your family had any of the following illnesses? If yes, please identify the family member.

YES NO If yes, who?
Lung disease/asthma/emphysema _____
Heart disease, heart attack _____
High blood pressure _____
Diabetes _____
Cancer _____
Arthritis _____
Other _____

SOCIAL HISTORY

Marital status ___S___M___W___D If married, spouse's name: _____
How many children? _____ Ages? _____
Current employer _____ Job description _____
Occupational history (previous positions held) _____
Do you smoke cigarettes? ___ If yes, how many packs per day? ___ How long? ___
Do you drink alcohol? ___ If yes, how many days per week? ___ Drinks per day? ___
Do you have a current or past history of substance abuse? ___ If yes, please explain _____
Please list your hobbies, sports, interests _____

RESPONSIBLE PARTY INFORMATION: If patient is a minor, who is financially responsible? _____ SS# _____

Employer: _____ Work phone _____ Birth date _____

If patient is a minor, please list name of person bringing this child to our office _____

Relationship to patient (please circle): MOTHER FATHER STEPMOTHER
STEPFATHER LEGAL GUARDIAN
OTHER: _____

Patient/Legal Guardian Signature Date

Dr. initials date