Sam Speron, M.D., F.A.C.S.
950 N Northwest Highway
Suite 102
Park Ridge, IL 60068

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential & will become part of your medical record.

Please take the time to circle or check or fill in answers – this is important information to help us treat you!

Name *(Last, First, M.I.):*	M F	**DOB:**

Marital status: Single Partnered Married Separated Divorced Widowed **Email Address:**

Who recommended me to you? Physician Friend Relative
Advertising: Internet (Google, Yahoo, MSN, Other) Magazine Yellow Pages

Referring doctor:	Date of last physical exam:	
May I send a thank you letter to the person who referred you?	Yes	No
Do you know anyone who has undergone the procedure you are interested in?	Yes	No
Have you done any reading about the procedure you are interested in?	Yes	No

What types of plastic surgery are you interested in discussing?

Skin Cancer	Moles	Breast Surgery	Facial Surgery
Body Contouring	Body Lifting	Laser procedure	Skin care

PERSONAL HEALTH HISTORY

Past Medical History

□ AIDS □ Chicken Pox □ High Cholesterol □ Polio
□ Alcoholism □ Cold Sores □ HIV Positive □ Prostate Problem
□ Anemia □ Diabetes □ Hypertrophic Scars □ Psychiatric Care
□ Anorexia □ Emphysema □ Keloid Scars □ Rheumatic Fever
□ Appendicitis □ Epilepsy □ Kidney Disease □ Scarlet Fever
□ Arthritis □ Glaucoma □ Liver Disease □ Stroke
□ Asthma □ Goiter □ Measles □ Suicide Attempt
□ Bleeding Disorders □ Gonorrhea □ Migraine Headaches □ Thyroid Problems
□ Breast Lump □ Gout □ Miscarriage □ Tonsillitis
□ Bronchitis □ Heart Disease □ Mononucleosis □ Tuberculosis
□ Bulimia □ Hepatitis □ Multiple Sclerosis □ Typhoid Fever
□ Cancer □ Hernia □ Mumps □ Ulcers
□ Cataracts □ Herpes □ Pacemaker □ Vaginal Infections
□ Chemical Dependency □ High Blood Pressure □ Pneumonia □ Venereal Disease

Childhood illness: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio		
Immunizations and dates:	Tetanus	Pneumonia
	Hepatitis	Chickenpox
	Influenza	MMR *Measles, Mumps, Rubella*
List any medical problems that are not listed above		
Surgeries (please include cosmetic procedures)		

Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	Yes	No

Pregnancies

Year of Birth	Sex of Child	Vaginal or C-Section Delivery	Complications if any
	M F	**Vaginal C-Section**	
	M F	**Vaginal C-Section**	
	M F	**Vaginal C-Section**	
	M F	**Vaginal C-Section**	

List your prescribed medications or drugs and all over-the-counter items, such as vitamins, inhalers and herbal supplements		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

Do you take aspirin, aspirin-like compounds, (Motrin, Advil, Nuprin, Ibuprofen, Naprosyn, etc.) or aspirin containing preparations (Bufferin, Anacin, Excedrin, Dristan, Midol, Empirin, Alka Seltzer, Fiorinal or Percodan?

YES NO

If you have had previous surgery, did any medications make you nauseated? YES NO
If yes, please list them:

Please list any pain medication(s) that work well for you (that is relieved your pain and did not make you nauseated):

HEALTH HABITS AND PERSONAL SAFETY

Exercise	Sedentary (No exercise)				
	Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	Occasional vigorous exercise (i.e. work or recreation, less than 4 times per week for at least 30 minutes)				
	Regular vigorous exercise (i.e. work or recreation > 4 times per week for at least 30 minutes)				
Diet	Are you dieting?			Yes	No
	If yes, are you on a physician prescribed medical diet?			Yes	No
	Number of meals you eat in an average day? One Two Three Four > Five				
	Rank salt intake	Hi	Medium	Low	
	Rank fat intake	Hi	Medium	Low	

	Rank sugar intake	Hi	Medium	Low		
Caffeine	None	Coffee	Tea	Cola		
	Number of cups/cans per day?					
Alcohol	Do you drink alcohol?				Yes	No
	If yes, what kind?					
	If yes, how many drinks per week? 1 2 3 4 5 6 7 8 > 9					
	Are you concerned about the amount you drink?				Yes	No
	Have you considered stopping?				Yes	No
	Have you ever experienced blackouts?				Yes	No
	Are you prone to "binge" drinking?				Yes	No
	Do you drive after drinking?				Yes	No
Tobacco	Do you use tobacco?				Yes	No
	Cigarettes – pks./day		Chew - #/day	Pipe - #/day	Cigars - #/day	
	# of years	Or year quit				
Drugs	Do you currently use recreational or street drugs?				Yes	No
	Have you ever given yourself street drugs with a needle?				Yes	No
Sex	Are you sexually active?				Yes	No
	If yes, are you trying for a pregnancy?				Yes	No
	If not trying for a pregnancy, list contraceptive or barrier method used:					
	Any discomfort with intercourse?				Yes	No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				Yes	No
Personal Safety	Do you live alone?				Yes	No
	Do you have frequent falls?				Yes	No
	Do you have vision or hearing loss?				Yes	No
	Do you have an Advance Directive and/or Living Will?				Yes	No
	Would you like information on the preparation of these?				Yes	No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				Yes	No

Occupational

Check (√) if your work exposes you to the following:

	Stress		Hazardous Substances
	Heavy Lifting		Other

What is your occupation?____

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	M F	
Mother				M F	
Sibling	M F			M F	
	M F			M F	
	M F		*Additional Information:*		
	M F				

Notes:

Review of Symptoms

Check (√) symptoms you currently have or have had in the past year:

General	**Gastrointestinal**	**Ear, Eyes, Nose, Throat**	**Men Only**
□ Chills	□ Appetite Poor	□ Bleeding Gums	□ Breast Lump
□ Depression	□ Bloating	□ Blurred Vision	□ Erection Difficulties
□ Dizziness	□ Bowel Changes	□ Crossed Eyes	□ Lump in Testicles
□ Fainting	□ Constipation	□ Difficulty Swallowing	□ Penis Discharge
□ Fever	□ Diarrhea	□ Double Vision	□ Sore on Penis
□ Forgetfulness	□ Excessive Hunger	□ Earache	□Other
□ Headache	□ Excessive Thirst	□ Ear Discharge	**Women Only**
□ Loss of Sleep	□ Gas	□ Hay Fever	□ Abnormal Pap Smear

□ Loss of Weight	□ Hemorrhoids	□ Hoarseness	□ Bleeding between Periods
□ Nervousness	□ Indigestion	□ Loss of Hearing	□ Breast Lump
□ Numbness	□ Nausea	□ Nosebleeds	□ Extreme Menstrual Pain
□ Sweats	□ Rectal Bleeding	□ Persistent Cough	□ Hot Flashes
Muscle/Joint/Bone	□ Stomach Pain	□ Ringing in Ears	□ Nipple Discharge
Pain, weakness and numbness in:	□ Vomiting	□ Sinus Problems	□ Painful Intercourse
□ Arms □ Hips	□ Vomiting Blood	□ Vision – Flashes	□ Vaginal Discharge
□ Back □ Legs	**Cardiovascular**	□ Vision – Halos	□ Other
□ Feet □ Neck	□ Chest Pain	**Skin**	Date of Last Menstrual Period: ___________________________
□ Hands □ Shoulders	□ High Blood Pressure	□ Bruise Easily	Date of Last Pap Smear: ___________________________
Genitourinary	□ Irregular Heart Beat	□ Hives	Have you had a Mammogram? ___________________________
□ Blood in Urine	□ Low Blood Pressure	□ Itching	Are you pregnant? _________
□ Frequent Urination	□ Poor Circulation	□ Change in Moles	Number of children? ________
□ Lack of Bladder Control	□ Rapid Heart Beat	□ Rash	
□ Painful Urination	□ Swelling of Ankles	□ Scars	
	□ Varicose Veins	□ Sore that won’t heal	

Additional Questions:

1. Do you worry about the appearance of your face or body? YES NO
2. If so, what is your specific concern?
3. How bad do you think your face or body part appears?
4. How much time do you spend worrying about the appearance of your face or body part?
5. Have you done anything to hide the problem or rid yourself of the problem?
6. Does this concern with your appearance affect any aspect of your life (eg. school, job, social life)

Name of Primary Care Doctor (Family Physician or Internist):

Address:

Phone:

Date of Last Visit:

Name of Obstetrician or Gynecologist:

Address:

Phone:

Date of Last Visit:

**** I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form. I realize that by giving false information, it may adversely affect the care I receive from Dr Speron.**

Patient Signature: **X** ______________________________ Date: DateToday

Reviewed by: ______________________________ Date: DateToday