

Park Ridge Center For Plastic Surgery, SC
 444 N Northwest Highway
 Suite 220
 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 (<i>Last, First, M.I.</i>):	M	F	DOB:
Marital status: Single Partnered Married Separated Divorced Widowed			
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

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

Childhood illness:	Measles	Mumps	Rubella	Chickenpox	Rheumatic Fever	Polio
Immunizations and dates:	Tetanus			Pneumonia		
	Hepatitis			Chickenpox		
	Influenza			MMR <i>Measles, Mumps, Rubella</i>		
List any medical problems that are not listed above						

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?
If yes, please list them:

YES NO

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		<i>Additional Information:</i>		
	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
<input type="checkbox"/> Chills	<input type="checkbox"/> Appetite Poor	<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Depression	<input type="checkbox"/> Bloating	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Erection Difficulties
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Bowel Changes	<input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> Lump in Testicles
<input type="checkbox"/> Fainting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Penis Discharge
<input type="checkbox"/> Fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Sore on Penis
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Earache	<input type="checkbox"/> Other

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 and the Park Ridge Center for Plastic Surgery.**

Patient Signature: **X** _____ Date: «DateToday»

Reviewed by: _____ Date: «DateToday»