DOWNEY
PLASTIC SURGERY

PLASTIC RECONSTRUCTIVE SURGERY HEALTH HISTORY

Patient: ______________________________ **Today's Date**: ____________________

Age: _______ **Height**: _______ **Weight**: ________ **BP**: ________ **Injury/Onset Date**: ______________

CHIEF COMPLAINT: ____
(What are you being seen for today?)

DISCOMFORT LEVEL: _______ On a scale from 1(low) – 10(high) please rate your pain or discomfort

		Yes	No
PRIMARY CARE PHYSICIAN:	NWH Provider?		
PREVIOUS PLASTIC SURGEON	NWH Provider?		
PHYSICIAN REQUESTING CONSULTATION	NWH Provider?		

REVIEW OF SYMPTOMS Are you currently experiencing any of the following? Check any that apply:

GENERAL:	Fever		Chills		Weight loss		Weight gain	
EYES:	Blurred vision		Double vision		Loss of sight		Other	
EARS/NOSE/THROAT:	Ringing in ears		Ear fullness/pressure		Swallowing problems		Hearing loss	
HEART:	Chest pain		Irregular heart beat		Palpitations		Other	
LUNGS:	Cough		Shortness of breath		Difficulty breathing		Other	
ALLERGY/IMMUN:	Dust		Pollen		Food		Latex	
INTESTINAL:	Upset Stomach		Bloody stools		Constipation		Diarrhea	
URINARY:	Burning		Frequent urination		Incontinence		Other	
MUSCULOSKELETAL:	Joint pain		Muscle weakness		Joint stiffness		Other	
SKIN:	Rashes		Sores		Masses		Scars	
NEUROLOGICAL:	Frequent Headaches		Head trauma/numbness		Vertigo/dizziness		Tremors	
PSYCHIATRIC:	Depression		Mood swings		Anxiety		Other	
ENDOCRINE:	Hair loss		Excessive thirst		Fatigue		Other	
BLOOD/LYMPHATIC:	Leg swelling		Bleeding tendency		Bruise easily		Other	
OB/GYN:	Currently Pregnant		Taking birth control pills		On Hormone Therapy		Menopausal	

ALLERGIES NONE: ____ or SEE ATTACHED LIST: _____

DRUG/SUBSTANCE		REACTION
Penicillin	Yes No	
Latex	Yes No	
Iodine	Yes No	
Tape	Yes No	
Other:		

CURRENT MEDICATIONS **None: _________ See attached list _______**

List all medications (include over-the-counter drugs and vitamins), date it was first prescribed and approximately how long taking each medication.

Date Began	Name of Medication / Product	Dosage	**Taking for?**	How long taking	Prescribing phsyician

PREVIOUS SURGERIES None: ______ or List surgical procedure and when performed

Surgical Procedure / Body Area	Date or Year Procedure done	Anesthesia Used Local General None	**Anesthesia Concerns or complications**

PAST MEDICAL HISTORY Have you ever had any of the following? **Check (✓) No or Yes**

	No	**Yes**	**Year**		**No**	**Yes**	**Year**		**No**	**Yes**	**Year**
Anemia				Cancer				**High Blood Pressure**			
Angina				Cancer Therapy				Kidney Disease			
Arthritis				Depression				Stomach Ulcers			
Asthma				Diabetes				Stroke			
Bad Teeth				Emphysema				Sun Exposure			
Bleeding problems				Epilepsy				Thyroid Disorders			
Blood Clots				Heart Attack				Other			

FAMILY HISTORY

Family History of	Yes	No	Unknown	**Who** (mother, father, sister, brother, etc…)
Arthritis?				
Cancer?				Type of cancer?
Breast cancer?				
Skin cancer or disease?				
Heart Disease?				
Stroke?				

SOCIAL HISTORY

	No	Yes	How Often/Much
Caffeine Use?	_____	_____	_______________
Tobacco Use?	_____	_____	_______________
Drug Use?	_____	_____	_______________
Alcohol Use?	_____	_____	_______________
Do you drive?	_____	_____	_______________

What is your occupation? __________________ Yrs ______

Marital Status: Single Married Divorced Other __________
(circle one)

Education 1 2 3 4 5 6 7 8 9 10 11 12 13+ (circle highest)

Patient Signature: ____
Date: ____

Provider Reviewed: ________________________________
Date: ________________________________