

**UT SOUTHWESTERN
MEDICAL CENTER**

UNIVERSITY HOSPITALS & CLINICS

Department of Plastic Surgery

Confidential Health Questionnaire

Pt. Name: _____
 Address: _____
 _____ City _____ State _____ Zip _____
 MRN: _____
 DOB: _____
 SSN: XXX-XX-_____
 DOS: _____ SEX: _____

Please help us assure you the highest quality care by answering carefully.

Age on this visit: _____ Occupation: _____

Whom may we thank for this referral? _____

This consultation is to discuss: _____

Allergies <i>Please list</i>	Medication(s) and type of reaction: _____ Tape/type: _____ Soap(s): _____ Food(s): _____
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Current Medications <i>Please list</i>	<table border="0" style="width: 100%;"> <tr> <td style="text-align: center;">Medication(s)</td> <td style="text-align: center;">Dosage</td> <td style="text-align: center;">Last time taken</td> <td style="text-align: center;">Medication(s)</td> <td style="text-align: center;">Dosage</td> <td style="text-align: center;">Last time taken</td> </tr> <tr> <td>1. _____</td> <td></td> <td></td> <td>4. _____</td> <td></td> <td></td> </tr> <tr> <td>2. _____</td> <td></td> <td></td> <td>5. _____</td> <td></td> <td></td> </tr> <tr> <td>3. _____</td> <td></td> <td></td> <td>6. _____</td> <td></td> <td></td> </tr> </table>	Medication(s)	Dosage	Last time taken	Medication(s)	Dosage	Last time taken	1. _____			4. _____			2. _____			5. _____			3. _____			6. _____		
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Personal Physician	Name of personal/regular physician: _____ Address: _____ Telephone: (_____) _____ Specialty: _____ Date of last physical exam: _____ Results: _____
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Medical History	<p>Please fill in the appropriate circle(s) if you currently have, or have had, any of the following:</p> <table border="0" style="width: 100%;"> <tr> <td><input type="radio"/> Prolonged bleeding when cut</td> <td><input type="radio"/> Blood disorders (anemia, etc.)</td> </tr> <tr> <td><input type="radio"/> Fainting or blackout episodes</td> <td><input type="radio"/> Thyroid problems</td> </tr> <tr> <td><input type="radio"/> High blood pressure</td> <td><input type="radio"/> Herpes, fever blisters</td> </tr> <tr> <td><input type="radio"/> Ulcer disease</td> <td><input type="radio"/> Skin disorders</td> </tr> <tr> <td><input type="radio"/> Heart disease and/or attack</td> <td><input type="radio"/> Eyes: burning, dryness, itching</td> </tr> <tr> <td><input type="radio"/> Immune disorders</td> <td><input type="radio"/> Rheumatic Fever</td> </tr> <tr> <td><input type="radio"/> Heart murmur</td> <td><input type="radio"/> Cancer</td> </tr> <tr> <td><input type="radio"/> Heart valve disorder</td> <td><input type="radio"/> Diabetes</td> </tr> <tr> <td><input type="radio"/> Kidney problems</td> <td><input type="radio"/> Irregular heart beat, palpitations</td> </tr> <tr> <td><input type="radio"/> Hepatitis</td> <td><input type="radio"/> Shortness of breath</td> </tr> <tr> <td><input type="radio"/> Lung/respiratory problems</td> <td><input type="radio"/> Swelling of ankles</td> </tr> </table> <p>Are you pregnant? <input type="radio"/> No <input type="radio"/> Yes Date of last menstrual period: _____ How many pregnancies: _____</p> <p>If you answered yes to any of the above, please explain: _____ _____</p>	<input type="radio"/> Prolonged bleeding when cut	<input type="radio"/> Blood disorders (anemia, etc.)	<input type="radio"/> Fainting or blackout episodes	<input type="radio"/> Thyroid problems	<input type="radio"/> High blood pressure	<input type="radio"/> Herpes, fever blisters	<input type="radio"/> Ulcer disease	<input type="radio"/> Skin disorders	<input type="radio"/> Heart disease and/or attack	<input type="radio"/> Eyes: burning, dryness, itching	<input type="radio"/> Immune disorders	<input type="radio"/> Rheumatic Fever	<input type="radio"/> Heart murmur	<input type="radio"/> Cancer	<input type="radio"/> Heart valve disorder	<input type="radio"/> Diabetes	<input type="radio"/> Kidney problems	<input type="radio"/> Irregular heart beat, palpitations	<input type="radio"/> Hepatitis	<input type="radio"/> Shortness of breath	<input type="radio"/> Lung/respiratory problems	<input type="radio"/> Swelling of ankles
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PLASTIC SURGERY

Confidential Health Questionnaire

Pt. Name: _____
 Address: _____
 _____ City _____ State _____ Zip _____
 MRN: _____
 DOB: _____
 SSN: XXX-XX-_____
 DOS: _____ SEX: _____

Surgical History

Previous procedures and dates:
Cosmetic:
 Eye: _____
 Ear: _____
 Nose: _____
 Face: _____
 Breast: _____
 Body Contouring: _____
Other:
 Gallbladder: _____
 Appendix: _____
 GYN: _____
 Sinus/Nose: _____
 Abdominal: _____
 Breast: _____
 Tonsils: _____
 Eyes: _____
 Heart: _____
 Orthopedic: _____
 Hysterectomy: _____
 Other: _____
 Have you or anyone in your family had a reaction to general anesthesia? No Yes
 If yes, please explain: _____

Scarring

Have you formed excessive or unsatisfactory scars in the past? No Yes
 If yes, give locations: _____

Bleeding/ Transfusions

Have you taken aspirin, anti-inflammatory medications or blood thinners within the past two weeks?
 No Yes If yes, please list: _____
 Prolonged bleeding when cut and/or family history? No Yes
 Have you had blood transfusions? No Yes If yes, give date(s): _____
 Have you experienced a reaction to a transfusion? No Yes
 If yes, describe: _____

Personal Health Habits

Do you now smoke, or have you ever smoked? No Yes If yes, how many packs per day? _____
 Have you quit? No Yes If yes, when? _____
 Do you drink alcohol? No Yes If yes, how often? _____
 Do you use any non-prescription medications or drugs not already listed? No Yes
 If yes, please list: _____
 Do you use any diet medications? No Yes If yes, please list: _____
 Do you use St. John's Wort? No Yes
 If yes, please list your dosage and times you take it: _____
 Do you take Ginseng? No Yes
 If yes, please list your dosage and times you take it: _____
 Do you take Omega 3 supplements? No Yes
 If yes, please list your dosage and times you take it: _____
 Do you take any other herbal medications? No Yes If yes, please list: _____

PLASTIC SURGERY