POSER
PLASTIC SURGERY CENTER

HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Primary Care Doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed:

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and herbals

Name the Drug	Strength	Frequency Taken

Allergies to medications:	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# Of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# Of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				

FAMILY HEALTH HISTORY

Family History:	
Breast Cancer	☐ yes ☐ no
Melanoma	☐ yes ☐ no
Stroke	☐ yes ☐ no
High Blood Pressure	☐ yes ☐ no
Heart Disease	☐ yes ☐ no
Diabetes	☐ yes ☐ no
Kidney Disease	☐ yes ☐ no
Depression	☐ yes ☐ no

Past Medical History:

Heart Disease	☐ yes ☐ no	**Asthma**	☐ yes ☐ no
Arthritis	☐ yes ☐ no	**AIDS or HIV+**	☐ yes ☐ no
Rheumatic Fever	☐ yes ☐ no	**Stroke**	☐ yes ☐ no
Anemia	☐ yes ☐ no	**Hepatitis**	☐ yes ☐ no
Tuberculosis	☐ yes ☐ no	**Stomach Ulcer**	☐ yes ☐ no
Diabetes	☐ yes ☐ no	**Kidney Disease**	☐ yes ☐ no
Cancer	☐ yes ☐ no	**Thyroid Disease**	☐ yes ☐ no
Glaucoma	☐ yes ☐ no	**Bleeding tendency**	☐ yes ☐ no

WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Number of pregnancies?		
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last mammogram?		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin rash	☐ Swollen lymph nodes	☐ Recent changes in:
☐ Chronic diarrhea	☐ Easy Bleeding	☐ Rapid Heartbeat
☐ Jaundice	☐ Easy Bruising	☐ Energy level
☐ Depression	☐ Dry Eyes	☐ Ability to sleep
☐ Seizures	☐ Chronic cough	☐ Weight
☐ Joint or muscle pain	☐ Chest Pain	

I verify that the above information is true and accurate to the best of my knowledge.

X_____ _____

Signature of patient or parent if minor

Date

X_____

Physicians Signature