

PATIENT HEALTH QUESTIONNAIRE

PLASTIC SURGERY CENTER OF THE SOUTH

Date of Visit: _____ Name: _____ Nickname: _____

Height: _____ Weight: _____ DOB: _____ Age: _____

Emergency Contact: _____

Are you under a doctor's care? Yes No If yes, what condition is being treated: _____

Your Physicians Name: _____ Phone: _____

Date of Last Physical: _____ CXR: _____ EKG: _____

CONSTITUTIONAL		HEMATOLOGY	
Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive bleeding with surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastric Bypass	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
CARDIOVASCULAR		Blood clots in legs	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood clots in lungs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina or chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Thinners	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack (MI)	<input type="checkbox"/> Yes <input type="checkbox"/> No	MUSCULO-SKELETAL	
Heart valve problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back/Neck/Jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular pulse (arrhythmia)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial joints or mobility restrictions	<input type="checkbox"/> Yes <input type="checkbox"/> No
RESPIRATORY		NEUROLOGIC	
Sleep apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Strokes/TIA's	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease/Alzheimer's	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis (MS)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prolonged cough or shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures (epilepsy)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis (TB)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal Cord injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
GASTROINTESTINAL		PSYCHIATRIC	
Ulcers/Reflux/Gerd	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis/Cirrhosis/Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
Black or Bloody stools	<input type="checkbox"/> Yes <input type="checkbox"/> No	IMMUNOLOGIC	
GENITO-URINARY/KIDNEY		Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stones	<input type="checkbox"/> Yes <input type="checkbox"/> No	STD'S	<input type="checkbox"/> Yes <input type="checkbox"/> No
Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
ENDOCRINE		EYES/DENTAL	
Diabetes - Type I II	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glasses/Contacts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Crowns/Dentures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid - Hypo Hyper Other	<input type="checkbox"/> Yes <input type="checkbox"/> No		

If Yes: List and explain: _____

PLEASE ALSO COMPLETE THE REVERSE SIDE

Are you allergic to any medications, latex or rubber/food/seasonal, etc. YES NO

If Yes: List and explain: _____

List **any** illnesses you have had: _____ Include Month and Year (High Blood Pressure, Diabetes, Etc.)

None

List **any** Hospitalizations or Surgeries

None

Current Medications: Please list **all** medications, supplements, herbals, etc.

None

Female Patients **ONLY:** Could you be pregnant? Yes No Are you breastfeeding? Yes No
#_____Pregnancies #_____Deliveries Do you anticipate future pregnancies? Yes No

Social History: Please check the appropriate answer.

Marital Status: Single Married Divorced Separated Widowed
Alcohol Use: Never 1-3 Drinks/wk 4-6 Drinks/wk > 6 Drinks/wk Quit, year
Tobacco Use: Never Daily, current packs/day Quit, year # of years smoked
Drug Use: None Yes, type and frequency

Occupation: _____

Family History: Please list any diseases that run in your family.

Heart Disease	Stroke	Diabetes	Kidney Disease	Urinary Stones	Cancer	Prostate Cancer
<i>Age</i>	<i>State of Health</i>	<i>List any medical problems</i>	<i>Age at death</i>	<i>Cause of death</i>		

Father _____

Mother _____

Sisters _____

Brothers _____

Children _____

Date _____ Patient Signature _____

FOR DOCTORS USE ONLY - I have reviewed this questionnaire with the patient today

NOTES:

Today's Date _____ Signature _____