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