Changes Plastic Surgery
MEDICAL QUESTIONNAIRE

PATIENT NAME: _____ **DOB:** _____

MEDICAL PROBLEMS: (please list)

_____

_____

DISEASE YOU HAVE HAD THAT REQUIRED HOSPITALIZATION:

	DATE	AGE	CONDITION/ILLNESS	HOSPITAL NAME
1.				
2.				
3.				

CURRENT MEDICATIONS:

	NAME	DOSE	HOW OFTEN	DATE LAST TAKEN
1.				
2.				
3.				
4.				
5.				
6.				
7.				

ALLERGIES:

Are you allergic to any medication? **NO YES**
If yes, what medication? _____
What reaction do you have?(circle) Flushing ☐ Rash ☐ Dizziness ☐ Hives ☐
Swelling ☐ Loss of Consciousness ☐
Other: _____
Do medications have an unusual effect on you? ☐ **NO YES** ☐
If yes, what effect? _____
Are you allergic to adhesive tape? ☐ **NO YES** ☐
Are you allergic to iodine? ☐ **NO YES** ☐
Please list any other allergies: _____

HABITS:

Do you have alcoholic drinks more than 2 or 3 times per week? ☐ **NO** ☐ **YES**
If yes, how many per day? _____
Have you ever had alcoholic withdrawal (DT's)? ☐ **NO** ☐ **YES**
Do you smoke? ☐ **NO** ☐ **YES**
If yes, how many cigarettes a day? _____

PAGE TWO: **CHANGES PLASTIC SURGERY**

Patient Name: _____ **DOB:** _____

PAST SURGICAL HISTORY:
PLEASE LIST IN ORDER, ANY OPERATIONS YOU HAVE HAD:

	DATE	OPERATION	SURGEON	HOSPITAL NAME
1.				
2.				
3.				
4.				
5.				

Do you have metal in your body? YES NO - If yes, where? _____

FAMILY HISTORY (circle relationship):

FAMILY MEMBER	AGE (IF ALIVE)	AGE (IF DECEASED)	CAUSE OF DEATH	SERIOUS ILLNESS (HEART, DIABETES, ETC.)
Father				
Mother				
Bro/Sis/Son/Daughter				
Bro/Sis/Son/Daughter				
Bro/Sis/Son/Daughter				

Has anyone in your family had a tendency to bleed extensively?	**NO**	**YES**
Has anyone in your family had an unusual reaction to anesthesia?	**NO**	**YES**
Has anyone in your family had unexplained fevers following surgery?	**NO**	**YES**
Have you ever had a blood transfusion?	**NO**	**YES**
Is there ANY possibility of your being pregnant at this time?	**NO**	**YES**

HAVE YOU EVER HAD?	**IF YES, WHEN?**						
Heart Disease	YES	NO	_____	Eye Condition	YES	NO	_____
Heart Attack	YES	NO	_____	Ear Condition	YES	NO	_____
Angina	YES	NO	_____	Nose Condition	YES	NO	_____
Chest Pain	YES	NO	_____	Throat Condition	YES	NO	_____
High Blood Pressure	YES	NO	_____	Tuberculosis	YES	NO	_____
Stroke	YES	NO	_____	Valley Fever	YES	NO	_____
Frequent Headaches	YES	NO	_____	Thyroid Disease	YES	NO	_____
Mental Disease	YES	NO	_____	Glaucoma	YES	NO	_____
Suicidal Tendencies	YES	NO	_____	Drug Addiction	YES	NO	_____
Nerve or Muscle Disease	YES	NO	_____	Drug Withdrawal	YES	NO	_____
Fainting Spells	YES	NO	_____	Kidney Disease	YES	NO	_____
Lung Disease	YES	NO	_____	Hepatitis	YES	NO	_____
Bronchitis	YES	NO	_____	Diabetes	YES	NO	_____
Asthma or Wheezing	YES	NO	_____	Easy Bruising	YES	NO	_____
Emphysema	YES	NO	_____	Easy Bleeding	YES	NO	_____
Shortness of Breath	YES	NO	_____	Phlebitis	YES	NO	_____
Pulmonary Embolus	YES	NO	_____	Obesity	YES	NO	_____
Circulatory Disease	YES	NO	_____	Urinary Infection	YES	NO	_____
X-Ray Exposure	YES	NO	_____	Stomach Ulcers	YES	NO	_____
Radiation Exposure	YES	NO	_____	Arthritis	YES	NO	_____
Leukemia	YES	NO	_____	Other	YES	NO	_____
Cancer WHERE?	YES	NO	_____	Please List:	_____		
					_____		

Patient Signature: _____ Date: _____