ZOLLMAN PLASTIC SURGERY, PC
MEDICAL HISTORY QUESTIONNAIRE

NAME: ______________________ **SS#:** ______________________ **DATE:** ______________

Please answer all questions by circling YES or NO. If necessary, write additional information in the "COMMENTS" section.

1. HAVE YOU EVER EXPERIENCED OR BEEN TOLD YOU HAVE A HEART, CIRCULATION OR BLOOD PROBLEM? YES NO
   - A. HEART MURMUR YES NO
   - B. MITRAL VALVE PROLAPSE YES NO
   - C. HEART ATTACK: DATE ________ YES NO
   - D. IRREGULAR HEART BEAT YES NO
   - E. HIGH/LOW BLOOD PRESSURE YES NO
   - F. STROKE OR BLOOD CLOTS YES NO
   - G. ANEMIA/SICKLE CELL YES NO
   - H. ANGINA/CHEST PAIN YES NO
   - 1. BLEEDING PROBLEM YES NO
   - J. OTHER HEART PROBLEMS YES NO
   - K. SWOLLEN LEGS/ANKLES YES NO
   - L. SLEEP ON 3 OR MORE PILLOWS YES NO

2. DO YOU HAVE OR EVER HAD ANY LUNG OR BREATHING PROBLEMS? YES NO
   - A. ASTHMA YES NO
   - B. BRONCHITIS YES NO
   - C. PNEUMONIA YES NO
   - D. TUBERCULOSIS YES NO
   - E. CHRONIC LUNG DISEASE YES NO
   - F COUGH FREQUENTLY
     YES, COUGH UP ANYTHING? YES NO
   - G. DO YOU SMOKE? YES NO
     HOW MUCH PER DAY? ________
     # OF YEARS SMOKED? ________
   - H. ABNORMAL CHEST X-RAY YES NO
   - 1. SHORTNESS OF BREATH YES NO
     1. AT REST YES NO
     2. CLIMBING STAIRS YES NO
     3. WALKING BRISKLY YES NO

3. HAVE YOU EVER EXPERIENCED OR BEEN TOLD YOU HAVE DIGESTIVE OR STOMACH/LIVER PROBLEMS? YES NO
   - A. DIFFICULTY SWALLOWING YES NO
   - B. HIATAL HERNIA YES NO
   - C. GALL BLADDER DISEASE YES NO
   - D. JAUNDICE (YELLOW SKIN) YES NO
   - E. ULCERS YES NO
   - F HEPATITIS YES NO
   - G.DIARRHEA/CONSTIPATION YES NO
   - H.WEIGHT LOSS IN LAST 4 MONTHS WITHOUT DIETING YES NO
   - 1. EAT ANY SPECIAL DIET YES NO

4. HAVE ANY URINARY, KIDNEY OR BLADDER PROBLEMS? YES NO
   - A. KIDNEY STONES YES NO
   - B. FREQUENT INFECTIONS YES NO
   - C. DIFFICULT OR PAINFUL URINATION YES NO
   - D. UNABLE TO HOLD URINE YES NO

5. DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING:
   - A. SEIZURE OR CONVULSION YES NO
   - B. HISTORY OF HEADACHES YES NO
   - C. ARM OR LEG BECOMES WEAK OR NUMB YES NO

6. DO YOU HAVE OR EVER HAD:
   - A. DIABETES: IF YES,
     ARE YOU: DIET CONTROL _____
     INSULIN CONTROL _____
   - B.HYPOGLECEMIC (LOW SUGAR) YES NO
   - C.THYROID PROBLEMS YES NO

7. DO YOU HAVE OR EVER HAD:
   - A. PHYSICAL LIMITATIONS OR USE OF AIDES - (WALKER, WHEELCHAIR, ETC.) YES NO
   - B. ARTHRITIS YES NO
   - C. DIFFICULTY WALKING OR LYING FLAT YES NO
   - D. BACK PROBLEMS YES NO
   - E. DIFFICULTY HEARING OR DIFFICULTY SPEAKING YES NO

8. ANY MAJOR MEDICAL ILLNESSES? YES NO
   DESCRIBE ______________________

9. ANY VISION PROBLEMS? YES NO
   - A.GLASSES YES NO
   - B. CONTACT LENSES YES NO

10. DENTURES, CHIPPED TEETH, BRACES, BRIDGEWORK, PLATES, LOOSE TEETH (CIRCLE ITEM) YES NO

11. ARE YOU CURRENTLY UNDER THE CARE OF A PSYCHIATRIST/ PSYCHOLOGIST? YES NO

12. FOR WOMEN ONLY: IS THERE A POSSIBILITY THAT YOU ARE PREGNANT? YES NO
    DATE OF LAST MENSTRUAL PERIOD ______________

13. FOR CHILDREN UNDER 16: ARE IMMUNIZATIONS UP TO DATE? YES NO

14. HAVE YOU EVER HAD A POSITIVE HIV TEST? YES NO
    IF YES, IS THE HIV ACTIVE? YES NO

15. ADVANCE DIRECTIVE
    I DO NOT HAVE AN ADVANCE DIRECTIVE.
    — A. I WOULD LIKE INFORMATION ABOUT ADVANCE DIRECTIVES
    B. I DECLINE INFORMATION ABOUT ADVANCE DIRECTIVES.
    I HAVE AN ADVANCE DIRECTIVE ON FILE.
    — IF SO, WHERE? ______________

COMMENTS: ______________________

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LIST ALL MEDICATIONS YOU NOW TAKE, INCLUDING NON-PRESCRIPTION (OVER THE COUNTER) MEDICATIONS:

MEDICATION DOSE	HOW OFTEN?
SUPPLEMENTS	
HERBS	

LIST ANY ALLERGIES YOU MIGHT HAVE TO MEDICATIONS:

______________ ______________

______________ ______________

ALLERGIES TO: CONTACT ITEMS (FOOD, TAPE, SOAPS, LATEX)

______________ ______________

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LIST OPERATIONS/SURGERIES	YEAR

ANY COMPLICATIONS FROM SURGERY?
1. BLEEDING YES NO
2. INFECTION YES NO
3. THICK SCAR YES NO
4. SLOW TO HEAL YES NO
5. OTHER ______________

ANESTHESIA HISTORY

HAVE YOU OR A BLOOD RELATIVE EVER HAD A PROBLEM WITH GENERAL OR LOCAL ANESTHESIA? YES NO
- NAUSEA OR VOMITING YES NO
- DROP/INCREASED BLOOD PRESSURE YES NO
- DIFFICULTY IN "WAKING UP" YES NO
- INCREASED TEMPERATURE YES NO
- DIFFICULTY BREATHING YES NO

PLEASE COMPLETE THE FOLLOWING QUESTIONS

1. NAME OF FAMILY PHYSICIAN ______________
   LOCATION ______________
2. DO YOU CONSUME ALCOHOL YES NO
   HOW MUCH PER DAY ________
3. DO YOU HAVE HISTORY OF CANCER? YES NO
   IF YES, SITE: ______________
   DATE ______________
4. FAMILY HISTORY OF CANCER YES NO
   IF YES, SITE:
   RELATIONSHIP
5. WOULD YOU DESCRIBE YOURSELF AS EXTREMELY ANXIOUS IF CONSIDERING SURGERY? YES NO

My signature to the right certifies that this information is correct to the best of my knowledge.

____
PATIENT SIGNATURE

____
STAFF SIGNATURE