Dr. Andrews Plastic Surgery Health History Form

Name:_____ Today's Date:_____

Reason for Visit:_____

DOB:_____ Height:_____ Weight:_____ Gender: ☐ Male ☐ Female

Family Physician: _____ Referred by:_____

How did you hear about us:_____

Medication(s)/Dose/Frequency:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Drug Allergies/Reaction:

_____
_____
_____

Non-Drug Allergies/Reactions:

_____
_____
_____

Latex Sensitivity: ☐ Yes ☐ No If yes, please describe reaction:_____

Past Surgical History:

☐Appendix _____
☐Bladder/Urinary_____
☐Caesarean Section_____
☐Colon_____
☐Ear_____
☐Eye_____
☐Gallbladder_____
☐Heart_____
☐Hernia Repair_____
☐Hysterectomy/Oophorectomy_____
☐Joint Replacement _____
☐Kidney _____
☐Lung _____
☐Nasal/Sinus _____
☐Neck _____
☐Prostate/Testicle _____
☐Throat _____
☐Tonsillectomy/Adenoidectomy_____

Past Medical History:

☐Arthritis
☐Blood Clots
☐Cancer _____
☐Depression/Anxiety
☐Diabetes Mellitus
☐Eye Conditions
☐Heart Disease
☐Hepatitis B/C _____
☐High Blood Pressure
☐High Cholesterol
☐HIV/AIDS _____
☐Kidney Disease
☐Lung Disease
☐MRSA/VRE
☐Obstructive Sleep Apnea
☐Stomach/Intestinal Problems
☐Stroke
☐Thyroid Disorder
☐Tuberculosis
☐Ulcers
☐ STDS_____
_____

Other Medical Conditions:_____

Family History: Has any member of your family (father/mother/siblings/children/grandparents) ever had any of the following conditions:

☐Arthritis
☐Cancer
☐Diabetes Mellitus
☐Heart Disease
☐High Cholesterol/Lipids
☐Liver Disease/Hepatitis
☐High Blood Pressure
☐Kidney Disease
☐Lung Disease
☐Stroke
☐Stomach/Intestinal Problems

☐ *Unable to obtain family history*

Social History:

Work: ☐ Full-time ☐ Part-Time Occupation:_____

☐ Retired ☐ Student ☐ Unemployed

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you use alcohol: ☐ Yes, How many drinks per week _____ ☐ No

Do you use drugs for non-medicinal purposes: ☐ Yes ☐ No

Do you use nicotine/tobacco: ☐ Yes, How much/how long _____ ☐ No

Have you experienced any of the following symptoms in the *past month*:

General
☐ Fever
☐ Chills
☐ Heavy Sweating/Night Sweats
☐ Loss of Appetite
☐ Sleep Disturbances
☐ Unexplained Weight Loss/Gain

Ear/Nose/Throat
☐ Sore Throat
☐ Mouth Sores
☐ Nasal Congestion/Sinus Issues
☐ Hearing Loss

Respiratory
☐ Cough
☐ COPD
☐ Wheezing
☐ Recurrent Respiratory Infections
☐ Shortness of Breath

Eyes
☐ Blurry Vision
☐ Double Vision

Cardiovascular
☐ Chest Pain or Discomfort
☐ Swelling Feet, Ankles, Legs
☐ Irregular Heartbeat
☐ Heart Attack
☐ Palpitations
☐ Varicose Veins

Gastrointestinal
☐ Abdominal Pain
☐ Nausea/Vomiting
☐ Indigestion/Heartburn
☐ Bloody Stools
☐ Change in Bowel Habits
☐ Rectal Bleeding
☐ Diarrhea
☐ Constipation
☐ Swallowing Difficulties

Psychological
☐ Depression
☐ Anxiety

Genitourinary
☐ Painful Urination
☐ Frequent Urination
☐ Incontinence
☐ Skin
☐ Skin Rash
☐ Itching
☐ Discoloration
☐ Lumps or Masses

Musculoskeletal
☐ Joint Pain
☐ Joint Swelling
☐ Back Pain
☐ Neck Pain
☐ Limitation of Motion

Other:_____

Are you interested learning about any additional treatments and/or procedures? ☐ Yes ☐ No

Which treatments/procedures:

☐ Botox/Fillers
☐ Skin Tightening
☐ CoolSculpting
☐ Skincare
☐ Liposuction/Tummy Tuck
☐ Breast Augmentation
☐ Eyelid Procedures
☐ Other:_____