THE PLASTIC SURGERY GROUP OF ROCHESTER, LLC

Please answer all questions below to the best of your knowledge. The information provided by you will be used by your doctor in decisions regarding your care. This information will not be released without a written authorization from you.

Which hand do you write with (please circle) Left Right

Reason for today's visit: _____

DO YOU NOW HAVE, OR HAVE YOU HAD: (if yes check the space provided.)

General
- Unexplained weight loss _____
- Unexplained fever _____
- Other_____

Cardiac
- High blood pressure _____
- Heart failure _____
- Heart attack _____
- Mitral valve prolapse _____
- Other heart murmur _____
- High cholesterol _____
- Angina _____
- Peripheral vascular disease _____

Pulmonary
- Tuberculosis ____
- Emphysema ____
- Asthma ____

Endocrine
- Diabetes ____
- Diabetes (taking insulin) ____
- Thyroid disorder ____

Neurological
- Stroke ____
- Seizures ____

Musculoskeletel
- Arthritis ____
- Tendonitis ____
- where_____

Other
- Cancer _____
- where_____
- Leukemia _____
- Bleeding tendency _____
- HIV/AIDS _____
- Stomach ulcers _____
- Hepatitis A, B, or C _____

(please circle A,B, or C, above)
- Depression _____
- Anxiety _____
- Other(Please List) _____
- _____
- _____

Pharmacy:_____

List all medications and dosages: _____

_____ _____

_____ _____

List allergies to any medications: _____

LATEX ALLERGY ? Yes No

Do you have allergies to anything else?_____

List **all** operations you have had: _____

_____

List other serious injuries/accidents you have had: _____

SOCIAL HISTORY

Do you smoke now? No_____ Yes_____How much?_____How long?_____

Did you smoke in the past? No_____Yes_____How much?_____For how long?_____

When did you quit?_____

Do you regularly drink (circle) alcohol, beer, or wine? No_____Yes_____ How much?_____

HEIGHT_____ WEIGHT _____

Woman only: Any chance you are pregnant? No_____ Yes_____ EDD_____

Have you had a mammogram? No_____ Yes_____

If yes-date/location_____

Name:_____ **DOB:**_____

REVIEW OF SYSTEMS

In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed.

Const. (Health in General) ❑ No Problems; Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems; Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems; Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ❑ No Problems; Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ❑ No Problems; Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ❑ No Problems; Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems; Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integ. (Skin, Hair & Breast) ❑ No Problems; Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems; Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems; Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑ No Problems; Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems; Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems; Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

Has any family member ever had: (Father, mother, sister, brother)

	Yes	No	Relationship		Yes	No	Relationship
Cancer				Diabetes			
Kidney Disease				Thyroid Disease			
Heart Disease				Seizure Disorder			

High Blood Pressure				Stroke			
Arthritis				High Cholesterol			
Stomach Disease				Asthma			
Tuberculosis				Drug/Alcohol Abuse			

Above information has been reviewed with patient.

Doctor:_____ Date:_____