Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

# J. Brian Boyd, M.D., Inc.
Plastic and Reconstructive Surgery

# HEALTH QUESTIONNAIRE

Name_____ Date of birth_____

Referred by_____

Age_____ Height _____Weight _____ Why are you seeing the doctor today? _____

**List all hospitalizations and operations (including cosmetic surgery)**

| *Year* | *Hospital/Operation Type* | *Year* | *Hospital/Operation Type* |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**List all current daily medications (include vitamins, herbs, and over-the-counter medicines)**

_____ _____ _____

_____ _____ _____

**Does anyone in your family have (list which family member):**

☐ Diabetes_____ ☐ Cancer_____ ☐ Stroke_____

☐ Hypertension_____ ☐ Heart Disease_____ ☐ Other_____

**List all allergies (including latex)**

_____ _____

_____ _____

**Do you presently have or have you frequently had:**

| Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Bowel Problems | ☐ | ☐ | Anemia or Bleeding Tendency | ☐ | ☐ | Frequent Nasal Bleeding |
| ☐ | ☐ | Stroke | ☐ | ☐ | Stomach Ulcers | ☐ | ☐ | Seizures/Fainting Spells | ☐ | ☐ | Frequent Ear Problems |
| ☐ | ☐ | Heart Attack/Heart Disease | ☐ | ☐ | Bladder Infections | ☐ | ☐ | Back or Neck Injuries | ☐ | ☐ | Glasses/Contacts |
| ☐ | ☐ | Irregular Heart Beats | ☐ | ☐ | Hepatitis/Jaundice | ☐ | ☐ | Regularly take Aspirin or Steroids | ☐ | ☐ | Visual impairment/cataracts/dry eyes |
| ☐ | ☐ | Thrombophlebitis/Blood Clots | ☐ | ☐ | AIDS/HIV | ☐ | ☐ | Take Weight-Reducing Medication? | ☐ | ☐ | Cold Sores/Herpes |
| ☐ | ☐ | Chest Pain | ☐ | ☐ | Transfusions | ☐ | ☐ | Keloid/Hypertrophic Scars | ☐ | ☐ | Have you used Retin-A? |
| ☐ | ☐ | Shortness of Breath | ☐ | ☐ | Diabetes | ☐ | ☐ | Breast Lumps or Discharge | ☐ | ☐ | Have you ever taken Accutane? |
| ☐ | ☐ | Asthma/Emphysema/Wheezing | ☐ | ☐ | Thyroid Problems | ☐ | ☐ | Breast Implants | ☐ | ☐ | Hernia of _____ |
| ☐ | ☐ | Pneumonia or Tuberculosis | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Recent Weight Loss or Gain (amount) _____ | | | |
| ☐ | ☐ | Fractures? Where?_____ | | | | ☐ | ☐ | Cancer (location/date)_____ | | | |
| ☐ | ☐ | Other Health Issues_____ | | | | | | | | | |

**Have you ever had trouble with anesthesia:** General Anesthesia? _____ Local Anesthesia? _____

**Recent Examinations:** Physical ___Yes ___No _____Date Blood Tests ___Yes ___No _____Date

Chest XRay ___Yes ___No _____Date EKG ___Yes ___No _____Date

**Social History (check the appropriate box response or fill in the blank)**

***Smoking:*** ☐ *yes* ☐ *no* ☐ *in the past (list year you quit_____)*

***Alcohol:*** ☐ *frequently* ☐ *occasionally* ☐ *rare* ☐ *never*

***Marital Status:*** ☐ *single* ☐ *married* ☐ *divorced* ☐ *widowed* ***Occupation:*** _____

**Female patients:**

Mammogram (date) _____ Location _____ Results _____

Number of Pregnancies _____ Number of Births _____ Method of Birth Control _____

Could you be pregnant now? ☐ Yes ☐ No Are you attempting pregnancy? ☐ Yes ☐ No

***I certify that I have disclosed my medical history to the best of my knowledge.***

_____

Patient Signature Date

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