

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

HEALTH QUESTIONNAIRE

Name			Date of birth		
Referred by					
Age HeightWe			ay?		
List all hospitalizations and of Year Hospital/Operation Ty		- · · ·	e side of this form if insuffi Operation Type	cient room here)	
List all current daily medicat	ions (include vitamins,	herbs, and over-the-count	er medicines)		
Does anyone in your family I			List all allergies (i	ncluding latex)	
☐ Diabetes ☐ ☐ Hypertension ☐	Cancer				
	Ticart biscasc		 		
Do you presently have or ha	ve you frequently had:				
Yes No High Blood Pressure Stroke Heart Attack/Heart Disease Irregular Heart Beats Thrombophlebitis/Blood Clots Chest Pain/Angina Shortness of Breath Asthma/Emphysema/Wheezing Pneumonia or Tuberculosis Fractures? Where?	□ □ AIDS/HIV □ □ Transfusions □ □ Diabetes □ □ Thyroid Problems	☐ Regularly take Aspi ☐ Take Weight-Reduc ☐ Keloid/Hypertrophic ☐ Breast Lumps or Dis ☐ Breast Implants ☐ Recent Weight Loss	pells	impairment/cataracts/dry eyes cores/Herpes you used Retin-A? you ever taken Accutane?	
Have you ever had trouble w	vith: General Anesthes	ia?	Local Anesthesia?		
	ysicalYes	NoDate	Blood TestsYes	NoDate	
	est X-RayYes	_NoDate	EKGYes	NoDate	
Social History (check the app Smoking: □ yes Alcohol: □ frequently Marital Status: □ single	ropriate box response □ no □ occasionally □ married	or fill in the blank) □ in the past (list year you quit_ □ rare □ never □ divorced □ widowe	,		
Female patients:					
Mammogram (date) Location		n Results Of Births Method of Birth Control			
Could you be pregnant now?			npting pregnancy? Ye		
I certify that I have disclosed	my medical history to	the best of my knowledge.			
Patient Signature	Date	_			