BARNES-JEWISH Hospital BJC HealthCare | Washington University in St. Louis Physicians

General Health Questionnaire for Plastic Surgery

Please answer all questions on the following pages by placing a check mark in the appropriate YES or NO column. If necessary, write additional information in the Comment section.

Patient's Name _____ Date ____/____/____

Reason for Visit _____ Date of Birth ____/____/____

Please check how you heard about us.

☐ Web Site ☐ TV ☐ Radio ☐ Newspaper ☐ Magazine Ad ☐ Friend ☐ Physician Referral

Primary Care Physician

Name _____

Address _____

Phone _____

☐ **Referring Physician or** ☐ **Other (check which)**

Name _____

Address _____

Phone _____

CURRENT MEDICATIONS (prescribed and over-the-counter) It is ok to attach list.

_____ _____ _____ _____

_____ _____ _____ _____

Pharmacy Name _____ Phone Number _____ Zip Code _____

ALLERGIES TO MEDICATIONS

_____ _____ _____ _____

_____ _____ _____ _____

Do you have a LATEX allergy (check one) ☐ Yes ☐ No

DO YOU HAVE A HISTORY OF

Heart or Circulation Diseases

Heart murmur/valve disease	☐ Yes	☐ No
Heart attack: Month/Year _____	☐ Yes	☐ No
Irregular heartbeat/palpitations	☐ Yes	☐ No
High blood pressure/hypertension	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No
Stroke history	☐ Yes	☐ No
Anemia/sickle cell anemia	☐ Yes	☐ No
Angina/chest pain	☐ Yes	☐ No
Bleeding problems	☐ Yes	☐ No
Deep venous thrombosis/pulmonary embolism (blood clot in leg/lungs)	☐ Yes	☐ No
Swollen ankles/legs/poor circulation	☐ Yes	☐ No
Cardiac Cath, EKG, Stress Test	☐ Yes	☐ No

Musculoskeletal/Joint/Skin Diseases

Difficulty walking	☐ Yes	☐ No
Back pain/problems	☐ Yes	☐ No
Joint replacement	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Rashes	☐ Yes	☐ No
Itching	☐ Yes	☐ No
Sores	☐ Yes	☐ No
Other skin lesions?	☐ Yes	☐ No

DO YOU HAVE A HISTORY OF

Lung or Breathing Diseases

Asthma – Last attack _____	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Shortness of breath: (if yes, check when)	☐ Yes	☐ No
☐ Resting ☐ Walking ☐ Climbing stairs		
Chronic lung disease	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
If yes, were you hospitalized?	☐ Yes	☐ No
When _____		
Sleep apnea	☐ Yes	☐ No
Do you use CPAP?	☐ Yes	☐ No
Frequent/productive cough	☐ Yes	☐ No
Abnormal chest X-ray	☐ Yes	☐ No

Digestive/Stomach/Liver Diseases

Hiatal hernia	☐ Yes	☐ No
Acid reflux	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Jaundice (yellow skin)	☐ Yes	☐ No
Diarrhea/Constipation	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No

DO YOU HAVE A HISTORY OF

Head or Neurologic Diseases

Seizure or black outs ☐ Yes ☐ No
Frequent headaches ☐ Yes ☐ No
Weakness in an arm or leg ☐ Yes ☐ No

Endocrine/Immunologic Diseases

Diabetes (check all that apply) ☐ Yes ☐ No
Controlled by: ☐ diet ☐ insulin ☐ pills
Low blood sugar/hypoglycemia ☐ Yes ☐ No
Thyroid problems ☐ Yes ☐ No
Autoimmune/collagen vascular disease ☐ Yes ☐ No
Do you take steroids? (prednisone/other) ☐ Yes ☐ No

Infectious Diseases

Hepatitis B or C ☐ Yes ☐ No
HIV/AIDS ☐ Yes ☐ No
TB/positive PPD ☐ Yes ☐ No
Any other recent infections/cold? ☐ Yes ☐ No

DO YOU HAVE A HISTORY OF

Urinary/Kidney/Bladder Diseases

Renal failure and/or dialysis ☐ Yes ☐ No
Kidney stones ☐ Yes ☐ No
Frequent urinary infections ☐ Yes ☐ No
Urinary problems ☐ Yes ☐ No

ENT/OPHTHO

☐ Difficulty hearing ☐ Difficulty speaking
☐ Dentures ☐ Bridge ☐ Plate
☐ Chipped teeth ☐ Loose teeth
☐ Glasses ☐ Contact lenses
☐ Cataracts ☐ Glaucoma

Mental Health Issues

☐ Depression ☐ Anxiety ☐ Panic disorder
☐ Anorexia ☐ Bulimia ☐ Eating disorder
☐ Violent behavior history

FOR WOMEN ONLY

Any history of reproductive disease/Ca? ☐ Yes ☐ No
Could you possibly be pregnant? ☐ Yes ☐ No
Date of last menstrual period _____

Number of pregnancies _____ live births _____
Age at menopause _____

SOCIAL HISTORY

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Significant Partner

Occupation _____

Ages of Children _____ ☐ None

Cigarette use?
☐ Yes ☐ No
Packs per day _____
for _____ years
Date quit _____

Any other tobacco products? (pipe, cigar, chewing tobacco, etc.)
☐ Yes ☐ No

Alcohol use?
☐ Yes ☐ No
Drinks per day _____

Street drug use? (cocaine, PCP, methamphetamines, any IV drugs, marijuana)
☐ Yes ☐ No

FAMILY HISTORY Do any blood relatives have any:

Problems with anesthesia? ☐ Yes ☐ No
Relationship _____
Alive or deceased _____

Cancer, cardiac disease, diabetes or seizures? ☐ Yes ☐ No
Relationship _____
Alive or deceased _____

Other ☐ Yes ☐ No
Specify _____
Relationship _____
Alive or deceased _____

PAST MEDICAL/SURGICAL HISTORY

Have you ever had any problems with anesthesia? ☐ Yes ☐ No
Have you ever had any blood products or transfusion? ☐ Yes ☐ No If yes, any reaction? ☐ Yes ☐ No
List previous surgeries, any other hospitalizations/major illnesses or anything else we may have missed.

_____

_____

COMMENTS

_____

_____

What is your HEIGHT _____ WEIGHT _____

Completed by (check one): ☐ Patient ☐ Other Signature _____

Reviewed by (Physician Signature) _____ Date _____