



MONUMENT
Plastic Surgery

Find your beautiful self.

Confidential Health Questionnaire

Date _____

Name _____ Age _____

Primary Care Physician and city: _____

Referring Physician and city: _____

Reason for visit:

MEDICAL INFORMATION

Allergies None Latex Medications _____

Medications: Aspirin Y N Ibuprofen Y N Coumadin (warfarin) Y N Plavix Y N

Please list all prescription drugs, dietary supplements, nonprescription and herbal products

Past Medical History

Past or current medical problems (example: high blood pressure, thyroid disease, cancer, etc):

Operations and injuries (please include any complications):

Family Medical History (please explain if any of these conditions have affected a blood relative)

Cancer: _____

Heart disease (heart attacks, heart bypass surgery): _____

Abnormal reaction to anesthesia: _____

Abnormal or excessive bleeding: _____

Abnormal blood clotting (Deep Venous Thrombosis [DVT] or Pulmonary Emboli [PE]): _____

Social History

Current Occupation _____ Marital Status: M S D W

Do you smoke or use tobacco? _____ Packs per day ____ Year started _____ Year stopped _____

Number of children _____ Are you planning on having more children? _____

Do you drink alcohol? N Y Drinks per week ____ Do you use recreational drugs? N Y _____

Have you had any symptoms or history of the following: (if yes, please explain)

- Fevers, chills, weight loss: _____
- Upper respiratory infections, cold sores: _____
- Shortness of breath, cough: _____
- Chest pain, palpitations, heart disease: _____
- Nausea, vomiting, diarrhea, heartburn: _____
- Urinary tract infection, blood in the urine: _____
- Diabetes mellitus or thyroid disease: _____
- Skin lesions or skin cancer: _____
- Arthritis, muscle or joint pain: _____
- Bleeding disorders, blood clotting disorder, anemia: _____
- AIDS or HIV, other immune disorders: _____

Any additional information you would like the doctor to know about:

How did you hear about Scottsbluff Plastic Surgery: Doctor referral Referral from friend

Internet Newspaper/magazine ad Yellow pages Other: _____

Completed by: _____ Signature _____

OFFICE USE ONLY: _____

I have reviewed the above patient-supplied information _____ Date _____