HEALTH HISTORY

PLEASE PRINT

DOCTOR Feins

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Diplomate, The American Board of Plastic Surgery

TODAY'S DATE ______________

PATIENT'S NAME

AGE DATE OF BIRTH MALE / FEMALE GENDER (CIRCLE ONE) HEIGHT: WEIGHT:

PRIMARY CARE PHYSICIAN NAME, ADDRESS AND TELEPHONE NUMBER

REFERRING PHYSICIAN NAME, ADDRESS AND TELEPHONE NUMBER

DOES YOUR INSURANCE COMPANY REQUIRE A REFERRAL? YES/NO (CIRCLE ONE)

REASON FOR VISIT:

ARE YOU A FULL TIME STUDENT? ☐YES ☐NO

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES OR NO. ALL RESPONSES ARE KEPT CONFIDENTIAL.

1. **ARE YOU IN GOOD HEALTH?** Y N
2. **HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR?** Y N
3. **DATE OF LAST PHYSICAL EXAM:** ______________ Y N
4. **ARE YOU NOW UNDER A PHYSICIAN'S CARE?** Y N
5. **HAVE YOU HAD ANY SERIOUS ILLNESSES?** Y N
   - YEAR ______ REASON: ______________________
   - YEAR ______ REASON: ______________________
6. **HAVE YOU EVER HAD AN MRSA OR A VRE?** Y N
7. **HAVE YOU HAD ANY PRIOR HOSPITALIZATIONS?** Y N
   - YEAR ______ REASON: ______________________
   - YEAR ______ REASON: ______________________
8. **HAVE YOU HAD ANY PRIOR SURGERIES?** Y N
   - YEAR ______ REASON: ______________________
   - YEAR ______ REASON: ______________________
   - YEAR ______ REASON: ______________________
9. **ARE YOU A SMOKER?** Y N
   - I CURRENTLY SMOKE CIGARETTES. PACKS/DAY _____ Y N
   - I USED TO SMOKE CIGARETTES. PACKS/DAY _____ Y N
   - QUIT DATE: ______________________________
   - OTHER TOBACCO USE: Y N
   - PIPE Y N
   - CIGAR Y N
   - CHEW Y N
10. **DO YOU NOW HAVE OR HAVE YOU EVER HAD:** Y N
    - RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE? Y N
    - CONGENITAL HEART DISEASE? Y N
    - CARDIOVASCULAR DISEASE? (HEART ATTACK, HEART MURMUR, CORONARY ARTERY DISEASE,ANGINA, HIGH BLOOD PRESSURE, STROKE, PALPITATIONS, HEART SURGERY, PACEMAKER) Y N
    - RADIATION TREATMENT FOR CANCER? Y N
    - SEIZURES, CONVULSIONS, EPILEPSY, FAINTING, DIZZINESS? Y N
    - PSYCHIATRIC TREATMENTS, NERVOUS DISORDER OR BREAKDOWN? Y N
    - LIVER DISEASE (JAUNDICE, HEPATITIS?) Y N
    - KIDNEY DISEASE? Y N
    - DIABETES? Y N
    - PANCREATITIS? Y N
    - THYROID DISEASE (GOITER?) Y N
    - ARTHRITIS Y N
    - STOMACH ULCERS OR COLITIS? Y N
    - GLAUCOMA? Y N
    - FREQUENT OR RECURRENT COLD OR MOUTH SORES? Y N
    - IMPLANTS PLACED ANYWHERE IN YOUR BODY? (BREAST, HEART VALVE, HIP, KNEE?) Y N
    - LUNG DISEASE (ASTHMA, EMPHYSEMA, CHRONIC COUGH, BRONCHITIS, PNEUMONIA, TUBERCULOSIS, SHORTNESS OF BREATH, CHEST PAIN, SEVERE COUGHING? Y N
    - HERPES OR OTHER VIRAL INFECTIONS? Y N
    - EYE PROBLEMS Y N
    - HEARING LOSS? Y N
    - SINUS OR NASAL PROBLEMS? Y N
    - DENTURES? Y N
    - BLEEDING PROBLEMS? Y N
    - NOSE BLEEDS? Y N
    - BLEEDING GUMS? Y N
    - ANY DISEASE, DRUGS OR TRANSPLANT OPERATION THAT HAS DEPRESSED YOUR IMMUNE SYSTEM? Y N
    - RECURRENT INFECTIONS OF ANY KIND? Y N
    - BLOOD TRANSFUSION(S)? Y N
11. **DO YOU WEAR CONTACT LENSES?** Y N
12. **DO YOU WEAR HEARING AIDS?** Y N

13. DO YOU TAKE ASPIRIN REGULARLY? HOW OFTEN? ________ Y N

14. PLEASE LIST ALL CURRENT MEDICATIONS (OR PROVIDE A CURRENT LIST):

MEDICATION	DOSAGE

15. ARE YOU ALLERGIC OR HAVE HAD A BAD REACTION TO:

- LOCAL ANESTHETIC (NOVOCAINE, ETC.)?
- PENICILLIN, AMOXICILLIN, CEPHALOSPORINS OR OTHER ANTIBIOTICS?
- BARBITURATES, SEDATIVES, ETC.?
- ASPIRIN OR IBUPROFEN?
- CODEINE OR OTHER PAIN KILLERS?
- TAPE, LATEX OR RUBBER PRODUCTS?
- OTHER MEDICATIONS? PLEASE LIST:

16. WOMEN ONLY:

A. ARE YOU PLANNING PREGANANCY? Y N

B. COULD YOU BE PREGNANT NOW? Y N

C. NUMBER OF PREGNANCIES: ________________

D. NUMBER OF DELIVERIES: ________________

E. HAVE YOU EVER BREAST FED? Y N

F. DO YOU DO REGULAR BREAST EXAMS? Y N

G. DATE OF LAST MAMMOGRAM: ________________

H. DATE OF LAST PAP SMEAR: ________________

WE RECOMMEND REGULAR BREAST AND PELVIC EXAMS WITH YOUR DOCTOR OR GYNECOLOGIST

17. ALCOLHOL USE

DO YOU DRINK ALCOHOL? Y N

IF YES, HOW MANY DRINKS PER WEEK? ____________ Y N

IS YOUR ALCOHOL USE A CONCERN FOR YOU OR OTHERS? Y N

18. DRUG USE

DO YOU USE ANY RECREATIONAL DRUGS? Y N

HAVE YOU EVER USED NEEDLES TO INJECT DRUGS? Y N

19. BODY PIERCING

HAVE YOU PIERCED ANY PART OF YOUR BODY WITHIN THE LAST TWO WEEKS? Y N

20. OTHER

HAVE YOU EVER SOUGHT PROFESSIONAL CARE FOR DRUG ABUSE OR ALCOHOLISM Y N

DO YOU HAVE ANY OTHER DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK DR. FEINS SHOULD KNOW ABOUT? Y N

DO YOU HAVE OTHER CONCERNS THAT YOU WISH TO SPEAK TO DR. FEINS ABOUT PRIVATELY? Y N

I understand the importance of a truthful health history to assist Dr. Feins and his staff in providing the best care possible. I have had the opportunity to discuss my health history with my doctor. If you become a surgical candidate, this information will be shared with the surgical facility for pre-operative purposes.

I verify that the above information is true and accurate to the best of my knowledge as of today's date.

____ ________________

Signature of Patient or Parent/Guardian if patient is a minor Date

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