E A L T H

PLEASE PRINT

Plastic & Cosmetic Surgery
144 Tarrytown Road•Manchester, NH 03103
603.647.4430T•603.647.4877F•www.drfeins.net
Diplomate, The American Board of Plastic Surgery

TODAY'S DATE _____

_____
PATIENT'S NAME

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

ARE YOU IN GOOD HEALTH?	**Y**	**N**
HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR?	**Y**	**N**
DATE OF LAST PHYSICAL EXAM: _____	**Y**	**N**
ARE YOU NOW UNDER A PHYSICIAN'S CARE?	**Y**	**N**
HAVE YOU HAD ANY SERIOUS ILLNESSES?	**Y**	**N**
YEAR _____ REASON: _____		
YEAR _____ REASON: _____		
HAVE YOU EVER HAD AN MRSA OR A VRE?	**Y**	**N**
HAVE YOU HAD ANY PRIOR HOSPITALIZATIONS?	**Y**	**N**
YEAR _____ REASON: _____		
YEAR _____ REASON: _____		
HAVE YOU HAD ANY PRIOR SURGERIES?	**Y**	**N**
YEAR _____ REASON: _____		
YEAR _____ REASON: _____		
YEAR _____ REASON: _____		
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**
DO YOU NOW HAVE OR HAVE YOU EVER HAD:	**Y**	**N**
• RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE?	**Y**	**N**
• CONGENITAL HEART DISEASE?	**Y**	**N**

• RADIATION TREATMENT FOR CANCER?	**Y**	
• SEIZURES, CONVULSIONS, EPILEPSY, FAINTING, DIZZINESS?	**Y**	
• PSYCHIATRIC TREATMENTS, NERVOUS DISORDER OR BREAKDOWN?	**Y**	
• LIVER DISEASE (JAUNDICE, HEPATITIS?)	**Y**	
• KIDNEY DISEASE?	**Y**	
• DIABETES?	**Y**	
• PANCREATITIS?	**Y**	
• THYROID DISEASE (GOITER?)	**Y**	
• ARTHRITIS	**Y**	
• STOMACH ULCERS OR COLITIS?	**Y**	
• GLAUCOMA?	**Y**	
• FREQUENT OR RECURRENT COLD OR MOUTH SORES?	**Y**	
• IMPLANTS PLACED ANYWHERE IN YOUR BODY? (BREAST, HEART VALVE, HIP, KNEE?)	**Y**	
• LUNG DISEASE (ASTHMA, EMPHYSEMA, CHRONIC COUGH, BRONCHITIS, PNEUMONIA, TUBERCULOSIS, SHORTNESS OF BREATH, CHEST PAIN, SEVERE COUGHING?	**Y**	
• HERPES OR OTHER VIRAL INFECTIONS?	**Y**	
• EYE PROBLEMS	**Y**	
• HEARING LOSS?	**Y**	
• SINUS OR NASAL PROBLEMS?	**Y**	
• DENTURES?	**Y**	
• BLEEDING PROBLEMS?	**Y**	
• NOSE BLEEDS?	**Y**	
• BLEEDING GUMS?	**Y**	
• ANY DISEASE, DRUGS OR TRANSPLANT OPERATION THAT HAS DEPRESSED YOUR IMMUNE SYSTEM?	**Y**	
• RECURRENT INFECTIONS OF ANY KIND?	**Y**	
• BLOOD TRANSFUSION(S)?	**Y**	
11. DO YOU WEAR CONTACT LENSES?	**Y**	

**CORONARY ARTERY DISEASE,ANGINA, HIGH BLOOD PRESSURE,
STROKE, PALPITATIONS, HEART SURGERY, PACEMAKER)**

3. DO YOU TAKE ASPIRIN REGULARLY? HOW OFTEN? _____ Y N

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

MEDICATION	DOSAGE

5. 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

B. COULD YOU BE PREGNANT NOW? Y

C. NUMBER OF PREGNANCIES: _____

D. NUMBER OF DELIVERIES: _____

E. HAVE YOU EVER BREAST FED? Y

F. DO YOU DO REGULAR BREAST EXAMS? Y

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

IF YES, HOW MANY DRINKS PER WEEK? _____

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

18. DRUG USE

DO YOU USE ANY RECREATIONAL DRUGS? Y

HAVE YOU EVER USED NEEDLES TO INJECT DRUGS? Y

19. BODY PIERCING

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

20. OTHER

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

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

DO YOU HAVE OTHER CONCERNS THAT YOU WISH TO Y

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