The Hand & Plastic Surgery Center of Katy PLLC

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PLASTIC SURGERY HEALTH INFORMATION

Name: _____ ☐MALE ☐FEMALE Date of Birth:_____

Why are you seeing the doctor? _____

REFERRING PHYSICIAN: _____ Phone Number: (____) ____-____

Address: _____ City, State, ZIP: _____

PRIMARY PHYSICIAN: _____ Phone Number: (____) ____-____

Address: _____ City, State, ZIP: _____

GENERAL HISTORY Height ____ft. ____inches Weight_____lbs.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment: ☐ Employed ☐ Unemployed ☐ Student ☐ Retired ☐ Minor

Occupation: _____

Are you currently working? ☐ Yes ☐ No If no, what was your last day of work? _____

Are you currently on restricted duty? ☐ No ☐ Yes If yes, please describe: _____

List sporting/recreational activities you participate in: _____
_____

Alcohol: ☐ Non-drinker ☐ Drink alcohol (Average # of drinks per week) _____

Tobacco: ☐ Non-smoker Date quit _____ ☐ Smoker _____ pack(s) per day for _____years

Recreational Drugs: Type _____ How often _____ for _____years

LIST PAST SURGERIES & Dates (Include cosmetic and outpatient surgeries)

_____
_____
_____
_____
_____
_____

HOSPITALIZATIONS & Dates

_____
_____
_____
_____
_____
_____

(PLEASE TURN OVER AND COMPLETE SIDE 2)

YOUR MEDICAL HISTORY (check box and explain in space provided)

☐ Diabetes _____
☐ Heart Disease/Heart Attack_____
☐ High Cholesterol_____
☐ High Blood Pressure _____
☐ Irregular Heart Beat _____ ☐ Pacemaker
☐ Vascular Disease _____
☐ Blood clots (DVT/PE)_____
☐ Blood thinner/Bleeding Tendency _____
☐ Sleep Apnea_____
☐ Lung Disease_____
☐ Asthma_____ ☐ COPD_____
☐ Hepatitis/Liver Disease_____
☐ Kidney Disease _____
☐ GI Disorder_____
☐ Reflux _____
☐ Cancer_____
☐ Surgery ☐ Chemotherapy ☐ Radiation _____

☐ Autoimmune Disorder _____
☐ Arthritis _____
☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Gout
☐ Osteoporosis_____
☐ Skin disorder ___ _____
☐ Skin cancer ☐ Melanoma ☐ Keloid/adverse scar ☐ Psoriasis
☐ Thyroid disorder _____
☐ Neurologic disorder _____
☐ Anxiety _____
☐ Depression _____
☐ Bipolar Disorder _____
☐ Body dysmorphic Disorder
☐ Trauma _____
_____
☐ OTHER_____
_____

MEDICATIONS (Include birth control, over the counters and herbals) Dosage(Strength) Frequency (times per day)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
Do you take aspirin or anti-inflammatories? _____ _____ _____

ALLERGIES ☐ None ☐ Yes (Please include reaction) ☐ Latex?
_____
_____

FAMILY MEDICAL HISTORY (indicate which family member):
(F) Father (M) Mother (B) Brother (S) Sister (G) Grandparents (A) Aunt (U) Uncle
☐ Diabetes_____ ☐ Heart Disease_____ ☐ Cancer_____ ☐ Autoimmune Problems_____
☐ Blood clots_____ ☐ Bleeding Problems_____ ☐ Anesthesia Problems_____ ☐ Other_____

REVIEW OF HEALTH: Please check if you have experienced any of the following **IN THE LAST 30 DAYS**:

☐ Weight loss **EXCLUDING** dieting
☐ Fever or night sweats
☐ Fatigue
☐ Swollen lymph nodes (glands)
☐ HIV/AIDS
☐ Easy bleeding or bruising
☐ Rashes
☐ Headaches
☐ Concussion or head trauma
☐ Dizzy spells
☐ Incoordination/imbalance
☐ Fainting
☐ Visual changes
☐ Ringing in the ears
☐ Chest pain
☐ Palpitations
☐ Circulatory problems
☐ Cough
☐ Shortness of breath
☐ Jaundice/yellow skin
☐ Abdominal pain
☐ Ulcers (stomach)
☐ Diarrhea
☐ Nausea and vomiting
☐ Constipation
☐ Passing bloody or black stools
☐ Painful urination
☐ Blood in urine
☐ Urinary retention
☐ Post-menopausal
☐ Last menstrual period _____
☐ Others _____
_____

_____ _____ _____
Patient Signature Date MD's initials