THE University of Vermont HEALTH NETWORK

AMERICAN SOCIETY OF PLASTIC SURGEONS

Patient Label

DIVISION OF PLASTIC, RECONSTRUCTIVE AND COSMETIC SURGERY

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New Patient Questionnaire

This questionnaire is for all new patients. It has been designed to gather information from you, the patient or someone whom you designate so that we may develop a plan of care that most appropriately fits your needs. Please be specific and provide us with as much information as possible. Please note that photographs are a standard part of plastic surgery and will stay in your medical record.

HISTORY OF PRESENT ILLNESS

Name: _____ Date of Birth: _____

What is the reason for your visit today? _____

Who referred you here? _____

Who is your family physician? _____

Do you have pain? _____

On the scale below, please indicate your present pain level:

0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Worst Pain)

Height: _____ Weight: _____

MEDICAL HISTORY – PAST AND PRESENT CONDITIONS/PROBLEMS

Please circle all physician diagnosed medical conditions and give month/year of diagnosis:

Allergies _____
Anemia _____
Anxiety _____
Arthritis _____
Asthma _____
Blood Clots _____
Bleeding Disorder _____
Breast Cancer _____
Cancer (Indicate type): _____
Cataracts _____
CHF_____
Clotting Disorder _____
COPD _____
Depression _____
Diabetes Mellitus _____
Emphysema _____
GERD _____
Glaucoma _____
Heart Attack/Angina _____
Heart Murmur _____
Hepatitis _____
High Blood Pressure _____
High Cholesterol _____
HIV/AIDS _____
Kidney Disease _____
Leukemia _____
Nerve/Muscle Disease _____
Osteoporosis _____
Seizures _____
Sickle Cell _____
Stroke _____
Thyroid Disease _____
Tuberculosis _____
Ulcers _____

ALLERGIES

Do you have any allergies (medications, environmental or food)? Y or N If yes, please list:

_____
_____

Do you have a Latex Allergy? Y or N
If yes, please describe your reaction: _____
Have you ever had complications from anesthesia (local or general) Y or N
If yes, please describe your reaction: _____

MEDICATIONS

If you have a printed medications list already, please let us know and we can make a copy. If not, please list all medications you are currently taking including prescriptions, over the counter and herbals/supplements:

_____

_____

_____

SURGICAL HISTORY

Please circle all surgeries you may have had, the procedure done and the date(s):

Appendectomy	Eye Surgery	Joint Replacement
Brain Surgery	Fracture Surgery	Prostate Surgery/Breast Surgery
Gallbladder Surgery	Spinal Surgery	Valve Replacement
Colon Surgery	Heart Surgery	Other: _____
Cosmetic Surgery	Hernia Repair	
C-Section	Hysterectomy	

Procedure done: _____ Date: _____
Procedure done: _____ Date: _____
Procedure done: _____ Date: _____

Is there a family history of any of the following conditions:

Cardiac (Heart) Y or N If yes, please indicate who: _____
Cancer Y or N If yes, please indicate type/who: _____

SOCIAL HISTORY

Do you currently use tobacco products? Y or N If so, how many packs/day? _____
Ready to quit? Y or N If you used previously, provide quit date: _____

Do you consume alcoholic beverages? Y or N If so, drinks/week: _____
If so, what do you consume? _____

Do you use any recreational drugs? Y or N If so, please specify: _____

REVIEW OF SYSTEMS

<u>General</u>
Fever/Chills
Unexplained Weight Loss/Gain

<u>Endocrine</u>
Frequent Thirst

<u>Eyes, Ears, Nose or Throat</u>
Vision Problems
Hearing Loss/Problems
Difficulty Swallowing

<u>Lungs/breathing</u>
Persistent Cough
Coughed Up Blood
Breathing Difficulty

<u>Digestive System</u>
Persistent Constipation
Blood in Bowel Movements
Unexplained Changes in Bowel Habits
Ulcer Disease
Abdominal Pain

<u>Genitourinary</u>
Urgency or Burning with Urination
Urinary Tract Infection

<u>Musculoskeletal</u>
Joint Pain/Arthritis
Back Pain
Gout

<u>Skin</u>
Masses/Tumors
Rash
Scar Easily?

<u>Blood</u>
Bruise Easily?
Bleeding Disorder

<u>Nervous System</u>
Headache
Weakness, Numbness
Memory Impairment

MD/PA initials _____