

Crystal Plastic Surgeons, Inc. | Health History

Patient Name: _____ Birthdate: _____ Today's Date: _____

To help us meet all your healthcare needs, please fill out both sides of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Place of birth _____
 Occupation _____
 Handedness R or L _____
 Marital Status _____
 Hobbies _____
 Habits
 Smoking (type & amount per day) _____
 If former smoker, date quite _____
 Alcohol (type & amount per week) _____
 Caffeine (type & amount per day) _____
 Street drugs (type & amount per day) _____
 Usual weight _____
 Please list all allergies (food, drug, environment)

 When was your last physical exam? _____

Name of doctor _____
 Physician Phone _____
 Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred: none

 Please list all medicines you are currently taking (include non-prescription drugs): none

 Describe all serious accidents, severe injuries, head injuries, fractures or broken bones (include date occurred): none

Chief Complaints

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing: _____

Past Medical History

Have you ever had the following? (Check "no" or "yes," leave blank if uncertain.)

	No	Yes		No	Yes		No	Yes
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	Polio.....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolaps	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood or plasma transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Back trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Bladder infections	<input type="checkbox"/>	<input type="checkbox"/>	Date of last chest x-ray: _____			Bleeding tendency.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Any other disease	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	Hives or eczema	<input type="checkbox"/>	<input type="checkbox"/>	Please list: _____		
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV+	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Infectious mono.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Family History

Have any of your family members had the following? (Check "no" or "yes," leave blank if uncertain.)

	No	Yes	Relationship		No	Yes	Relationship
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding tendency.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family History (continued)

(Check "no" or "yes," leave blank if uncertain.)

If living: Present age and health (good, fair, poor)

If deceased: Age and cause of death

	No	Yes	Relationship	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Father _____
Chronic lung disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mother _____
Drug or alcohol problem	<input type="checkbox"/>	<input type="checkbox"/>	_____	Siblings _____
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Obesity.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Spouse _____
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Children _____
Depression.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Gout.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Do you have now, or have you had within the past year any of the following? (Check "no" or "yes," leave blank if uncertain.)

	No	Yes		No	Yes		No	Yes
Weakness or paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination (day)	<input type="checkbox"/>	<input type="checkbox"/>
Tire easily or weakness	<input type="checkbox"/>	<input type="checkbox"/>	Sore tongue or gums.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination (night).....	<input type="checkbox"/>	<input type="checkbox"/>
Recent weight changes.....	<input type="checkbox"/>	<input type="checkbox"/>	Lump or discharge from breast.....	<input type="checkbox"/>	<input type="checkbox"/>	Increase in thirst	<input type="checkbox"/>	<input type="checkbox"/>
Change in appetite.....	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to cold or heat.....	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	Leakage or urine.....	<input type="checkbox"/>	<input type="checkbox"/>
Persistent fever	<input type="checkbox"/>	<input type="checkbox"/>	Bloody sputum.....	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty starting urine	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats or hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing.....	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Skin rash.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain or discomfort.....	<input type="checkbox"/>	<input type="checkbox"/>	Backaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Skin trouble or changes	<input type="checkbox"/>	<input type="checkbox"/>	Purple fingers or lips	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain or stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Change in hair or nails.....	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of hands, feet or ankles....	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Muscle cramps or spasms	<input type="checkbox"/>	<input type="checkbox"/>
Easy bleeding or bruising.....	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations or heart fluttering	<input type="checkbox"/>	<input type="checkbox"/>	Sleeplessness.....	<input type="checkbox"/>	<input type="checkbox"/>
Double vision.....	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps on walking or at night ...	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged veins.....	<input type="checkbox"/>	<input type="checkbox"/>	Depression.....	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Infected eyes.....	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn.....	<input type="checkbox"/>	<input type="checkbox"/>	Poor coordination	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>	Frequent belching.....	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Date of your last eye exam: _____			Abdominal cramping	<input type="checkbox"/>	<input type="checkbox"/>	Men only:		
Ringing in the ears.....	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Discharge from penis.....	<input type="checkbox"/>	<input type="checkbox"/>
Discharge from ears.....	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Pain or lump in testicles	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>	Vomited or coughed up blood.....	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Decrease in hearing	<input type="checkbox"/>	<input type="checkbox"/>	Chronic diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Women only:		
Frequent nosebleeds.....	<input type="checkbox"/>	<input type="checkbox"/>	Chronic constipation	<input type="checkbox"/>	<input type="checkbox"/>	Date of last period: _____		
Frequent colds.....	<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Date of last mammogram: _____		
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	Black tarry stools.....	<input type="checkbox"/>	<input type="checkbox"/>	Type of birth control used: _____		
Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>	Dark urine	<input type="checkbox"/>	<input type="checkbox"/>	Number or pregnancies: _____		
Persistent hoarseness.....	<input type="checkbox"/>	<input type="checkbox"/>	Yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Number of full-term births: _____		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services (I) my child) may need.

Signature of patient (or parent if minor) Date

Signature of physician reviewing history Date

Physician's comment