Hendricks Regional Health Medical Group

# Hendricks Plastic & Reconstructive Surgery Patient History Form

**Patient Name** _____ **Date of Birth** _____

## History of Present Illness

Why are you being seen today?

_____

How long have you had this problem?

_____

What are you current symptoms?

_____

What tests have you had done in relation to this problem?

☐ CT ☐ MRI ☐ X-ray ☐ Upper GI ☐ Colonoscopy ☐ Ultrasound ☐ HIDA scan

☐ Other: _____

On scale of 0-10 (0 being no pain, 10 being most severe), please circle the # that best describes your pain, if applicable:

**0 1 2 3 4 5 6 7 8 9 10**

Please list any previous treatments you may have received for this problem:

_____

## Current Medications

Please list all medications you are taking at this time, including vitamins, supplements and herbal. Continue on back if needed.

| Name of Drug | Dose (include strength and # of pills per day) | How long have you taken this medication? | Why do you take this medication? |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |

## Past Medical History

*Please include all medical problems such as diabetes, hypertension, etc.*

## Psychological History

*Please list all diagnosis and treatments.*

## Allergies

*Please list all medications, foods and environmental agents are you allergic to. Please include what type of reaction(s) you have (hives, nausea, breathing problems, etc.).*

## Past Surgical History

*Please list all procedures including surgeries, colonoscopies, heart catheterizations, etc.*

## Hospitalizations

*Please list all reasons and dates.*

## Family History

*Please list all major medical conditions.*

Mother_____ Father _____

Brother(s) _____

Sister(s)_____

Children_____

Grandparents _____

## Social History

Marital Status_____ Spouse's Name _____ # of Children ____

Occupation _____ Hobbies/interests/sports_____

Tobacco use: **Never**
(*circle*) **Former** ____ packs/day for ____ years
**Current** ____ packs/day for ____ years

Alcohol use: _____ per day/week/month/year Type _____

Illegal Drug use: **Never**
(*circle*) **Former** Type _____ for _____ years
**Current** Type _____ for _____ years

Exercise: _____

Other important aspects of health history:_____

_____

_____

_____

_____

**Patient Signature** _____ **Date** _____

**Witness** _____ **Date** _____

# Review of Systems

*Please circle any symptoms you have had in the last seven (7) days.*

## Cardiology

| | | |
|---|---|---|
| Chest pain | YES | NO |
| Leg swelling | YES | NO |
| Varicose veins | YES | NO |
| Palpitations | YES | NO |

## Constitutional

| | | |
|---|---|---|
| Fatigue | YES | NO |
| Fever | YES | NO |
| Abnormal weight loss/gain | YES | NO |

## Dermatology

| | | |
|---|---|---|
| Change in skin/hair/nails | YES | NO |
| Breast lump | YES | NO |
| Rash | YES | NO |
| Itching | YES | NO |

## Endocrinology

| | | |
|---|---|---|
| Thyroid issues | YES | NO |
| Gland/Hormone issues | YES | NO |
| Diabetes | YES | NO |
| Heat intolerance | YES | NO |
| Cold intolerance | YES | NO |
| Skin changes | YES | NO |

## Ear/Nose/Throat

| | | |
|---|---|---|
| Sores in mouth | YES | NO |
| Ear pain | YES | NO |
| Sinus problems | YES | NO |
| Hearing loss | YES | NO |
| Ringing in ears | YES | NO |
| Nose bleeds | YES | NO |
| Sore throat | YES | NO |
| Swollen glands in neck | YES | NO |

## Female Reproductive

| | | | |
|---|---|---|---|
| Last pap smear date _____ | Normal? | YES | NO |
| Last mammogram _____ | Normal? | YES | NO |
| Abnormal vaginal discharge | | YES | NO |
| Vomiting | | YES | NO |
| Painful bowel movements | | YES | NO |
| Change in bowel habits | | YES | NO |
| Constipation | | YES | NO |
| Blood in stool | | YES | NO |

## Hematology/Lymphatic

| | | |
|---|---|---|
| Unusual bleeding/bruising | YES | NO |
| Phlebitis | YES | NO |
| Slow to heal after cuts | YES | NO |
| Anemia | YES | NO |
| Blood transfusion | YES | NO |

## Male Reproductive

| | | |
|---|---|---|
| Testicle pain | YES | NO |
| Sexual difficulties | YES | NO |

## Musculoskeletal

| | | |
|---|---|---|
| Muscle weakness | YES | NO |
| Muscle pain/cramps | YES | NO |
| Difficulty walking | YES | NO |
| Joint pain | YES | NO |
| Joint swelling | YES | NO |
| Joint stiffness | YES | NO |

## Neurology

| | | |
|---|---|---|
| History of head trauma | YES | NO |
| History of stroke | YES | NO |
| Seizures | YES | NO |
| Tremors | YES | NO |
| Tingling/Numbness | YES | NO |
| Dizziness | YES | NO |
| Memory loss | YES | NO |

## Psychology

| | | |
|---|---|---|
| Anxiety/Nervousness | YES | NO |
| Depression | YES | NO |

## Respiratory

| | | |
|---|---|---|
| Shortness of breath w/ exercise | YES | NO |
| Shortness of breath lying down | YES | NO |
| Wheezing | YES | NO |
| Persistent cough | YES | NO |
| Coughing up blood | YES | NO |

## Urology

| | | |
|---|---|---|
| Change in force of strain while urinating | YES | NO |
| Urinary frequency | YES | NO |
| Pain during urination | YES | NO |
| Urinary incontinence | YES | NO |
| Blood in urine | YES | NO |
| Kidney stones | YES | NO |