HENDRICKS REGIONAL HEALTH
PLASTIC & RECONSTRUCTIVE SURGERY

Patient Name: test _____ Date: test _____

Current Medications

Please list all medications you are taking at this time, include vitamins, supplements & herbal or provide a complete list (use back if needed)

Name of Drug	Dose (include strength and number 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			

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

_____
_____
_____
_____

Past Medical History- *Please include all medical problems such as diabetes, hypertension, etc.*

_____
_____
_____
_____

Past Surgical History- *Please list all procedures including surgeries, colonoscopies, heart catheterizations, etc.*

_____
_____
_____
_____

Family History-*Please list all major medical conditions.*

Mother _____
Father _____
Brother(s) _____
Sister(s) _____
Specify grandmother as GM grandfather as GF
Maternal Grandparent_____
Paternal Grandparent _____
Other_____

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Patient Name: test _____ Date: test _____

Review of Systems (symptoms within the last 7 days)

Constitution
- Fatigue ☑YES ☐NO
- Fever ☐YES ☐NO
- Unexpected Weight Change ☐YES ☐NO
- Other_____

Ear/Nose/Throat
- Congestion ☐YES ☐NO
- Hearing loss ☐YES ☐NO
- Nosebleeds ☐YES ☐NO
- Sinus Pain ☐YES ☐NO
- Sore Throat ☐YES ☐NO
- Other_____

Eyes
- Visual Disturbance ☐YES ☐NO

Respiratory
- Sleep Apnea ☐YES ☐NO
- Cough ☐YES ☐NO
- Shortness of breath ☐YES ☐NO
- Wheezing ☐YES ☐NO
- Other_____

Cardiovascular
- Chest Pain ☐YES ☐NO
- Leg Swelling ☐YES ☐NO
- Palpitations ☐YES ☐NO
- Other_____

Gastroenterology
- Abdominal Pain ☐YES ☐NO
- Constipation ☐YES ☐NO
- Nausea ☐YES ☐NO
- Vomiting ☐YES ☐NO
- Other_____

Musculoskeletal
- Joint Pain ☐YES ☐NO
- Back pain ☐YES ☐NO
- Difficulty Walking ☐YES ☐NO
- Joint swelling ☐YES ☐NO
- Muscle pain ☐YES ☐NO

Skin
- Color Change ☐YES ☐NO
- Rash ☐YES ☐NO
- Wound ☐YES ☐NO

Immunosuppressed
- Immunocompromised ☐YES ☐NO
- Other_____

Neurological
- Dizziness ☐YES ☐NO
- Facial Asymmetry ☐YES ☐NO
- Headaches ☐YES ☐NO
- Light Headedness ☐YES ☐NO
- Numbness ☐YES ☐NO
- Seizure ☐YES ☐NO
- Fainting ☐YES ☐NO
- Weakness ☐YES ☐NO

Hematologic
- Bruises easily ☐YES ☐NO
- Other_____

Psychiatric
- Confusion ☐YES ☐NO
- Dysphoric mood ☐YES ☐NO
- Nervous/anxiety ☐YES ☐NO
- Suicidal Ideas ☐YES ☐NO

Endocrine
- Cold Intolerance ☐YES ☐NO
- Heat Intolerance ☐YES ☐NO

Other_____

Urinary/Reproductive
- Difficulty Urinating ☐YES ☐NO
- Painful Urination ☐YES ☐NO
- Frequent urination ☐YES ☐NO
- Blood in Urine ☐YES ☐NO
- Urgency ☐YES ☐NO

Female
- Vaginal bleeding ☐YES ☐NO
- Vaginal discharge ☐YES ☐NO

HENDRICKS REGIONAL HEALTH
PLASTIC & RECONSTRUCTIVE SURGERY

Patient Name: test _____ Date: test _____

Review of Systems Child (symptoms within the last 7 days)

Constitution
- Activity Change ☐YES NO☐
- Fever ☐YES NO☐
- Unexpected Weight Change ☐YES NO☐

Ears/Nose/Throat
- Congestion ☐YES NO☐
- Hearing loss ☐YES NO☐
- Nosebleeds ☐YES NO☐
- Sore Throat ☐YES NO☐

Eyes
- Visual Disturbance ☐YES NO☐

Respiratory
- Cough ☐YES NO☐
- Shortness of Breath ☐YES NO☐
- Wheezing ☐YES NO☐

Gastroenterology
- Abdominal pain ☐YES NO☐
- Constipation ☐YES NO☐
- Vomiting ☐YES NO☐

Endocrine
- Cold Intolerance ☐YES NO☐
- Heat Intolerance ☐YES NO☐

Urinary
- Difficulty urinating ☐YES NO☐
- Frequent Urination ☐YES NO☐
- Urgency ☐YES NO☐

Musculoskeletal
- Joint pain ☑YES NO☐
- Muscle pain ☐YES NO☐

Skin
- Color Change ☐YES NO☐
- Rash ☐YES NO☐
- Wound ☐YES NO☐

Immune
- Immunocompromised ☐YES NO☐

Hematologic
- Bruises easily ☐YES NO☐

Neurological
- Headaches ☐YES NO☐
- Seizure ☐YES NO☐

Behavioral
- Behavior problem ☐YES NO☐
- Hyperactive ☐YES NO☐
- Nervous/anxious ☐YES NO☐
- Suicidal ideas ☐YES NO☐