Medical History Form

Please complete all questions on form.

Patient Name: ____ DOB:______________ Age:_____________

Why are you here to see the doctor today?____

Have you (or any member of your family) ever been treated by a provider in this clinic for any condition before this visit?

No___ If Yes, Please explain____

____

Have you ever been treated by a Plastic or Hand Surgeon for any condition? _____No _____Yes

If so, when? _________________ Treated for what? ____

PLEASE LIST ALL MEDICATION YOU ARE TAKING REGULARLY:

NAME	REASON	DOSE	HOW OFTEN	START DATE

ALLERGIES	REACTION

PLEASE LIST ALL MEDICAL PROBLEMS	PAST SURGERIES & DATE

FAMILY HISTORY: If ANY of the following run in your family please specify which family member. Please note Alive and age or Deceased & age at death.

___Cancer_____________________________ ____Diabetes____________________________________

___Heart Disease______________________ ____Strokes_____________________________________

___Mental Disease_____________________ ____Other_______________________________________

Review of Systems

Please complete by circling in Yes or No for each question

General/Constitutional

Change in appetite	Yes	No
Chills	Yes	No
Fatigue	Yes	No
Fever	Yes	No
Headache	Yes	No
Lightheadedness	Yes	No
Night sweats	Yes	No
Sleep disturbance	Yes	No
Weight gain	Yes	No
Weight loss	Yes	No

Allergy/Immunology

Blistering of skin	Yes	No
Congestion	Yes	No
Cough	Yes	No
Hives	Yes	No
Itching	Yes	No
Rash	Yes	No
Sneezing	Yes	No
Watery eyes	Yes	No
Contact Allergy	Yes	No
Environmental allergies	Yes	No

Ophthalmologic

Blurred vision	Yes	No
Diminished visual activity	Yes	No
Discharge	Yes	No
Dry eye	Yes	No
Flashes of light in the vision	Yes	No
Floaters in the visual field	Yes	No
Itching and redness	Yes	No
Pain	Yes	No
Red eye	Yes	No
Vision screen	Yes	No

ENT

Blocked hearing	Yes	No
Decreased hearing	Yes	No
Decreased sense of smell	Yes	No
Difficulty swallowing	Yes	No
Dry mouth	Yes	No
Ear pain	Yes	No
Hearing screen	Yes	No
Nosebleed	Yes	No
Ringing in the ears	Yes	No
Sore throat	Yes	No

Endocrine

Cold intolerance	Yes	No
Difficulty sleeping	Yes	No
Dizziness	Yes	No
Excessive sweating	Yes	No
Excessive thirst	Yes	No
Frequent urination	Yes	No
Heat intolerance	Yes	No
Weakness	Yes	No
Weight loss	Yes	No

Respiratory

Breathing pattern	Yes	No
Chest pain	Yes	No
Cough	Yes	No
Hemoptysis	Yes	No
Pain with inspiration	Yes	No
Shortness of breath at rest	Yes	No
Shortness of breath with exertion	Yes	No
Wheezing	Yes	No
Sputum production	Yes	No

Cardiovascular

Chest pain at rest	Yes No
Chest pain with exertion	Yes No
Dizziness	Yes No
Irregular heartbeat	Yes No
Palpitations	Yes No
Shortness of breath	Yes No
Weakness	Yes No

Breast

Bloody nipple discharge	Yes No
Breas lump	Yes No
Breast pain	Yes No
Breast swelling	Yes No
Fever	Yes No
Nipple discharge	Yes No
Red skin	Yes No

Gastrointestinal

Abdominal pain	Yes No
Blood in stool	Yes No
Change in bowel habits	Yes No
Constipation	Yes No
Decreased appetite	Yes No
Diarrhea	Yes No
Difficulty swallowing	Yes No
Heartburn	Yes No
Nausea	Yes No
Rectal bleeding	Yes No
Vomiting	Yes No

Hematology

Breast lump	Yes No
Dizziness	Yes No
Easy bruising	Yes No
Fever	Yes No
Groin mass	Yes No
Prolonged bleeding	Yes No
Recent transfusion	Yes No
Swollen glands	Yes No
Weakness	Yes No
Weight loss	Yes No

Women only

Breast lump	Yes No
Breast pain	Yes No
Discharge from breast	Yes No
Heavy bleeding during menses	Yes No
Hot flashes	Yes No
Irregular menses	Yes No
Missed periods	Yes No
Painful intercourse	Yes No
Painful menses	Yes No
Vaginal bleeding between periods	Yes No
Vaginal discharge/itching	Yes No

Men only

Difficulty initiating stream	Yes No
Dribbling after urination	Yes No
Hard testicle	Yes No
Hernia	Yes No
Lump in groin	Yes No
Penile discharge	Yes No
Rash or blisters on penis	Yes No
Scrotal pain	Yes No
Scrotal swelling	Yes No
Undescended testicle	Yes No

Genitourinary

Abdominal pain/swelling	Yes No
Blood in urine	Yes No
Difficulty urinating	Yes No
Frequent urination	Yes No
Pain in lower back	Yes No
Painful urination	Yes No
Urinary incontinence	Yes No

Musculoskeletal

Carpal tunnel	Yes No
Joint stiffness	Yes No
Muscle aches	Yes No
Pain in shoulder	Yes No
Painful joints	Yes No
Leg cramps	Yes No
Weakness	Yes No

Skin		**Psychiatric**	
Acne	Yes No	Anxiety	Yes No
Blistering of skin	Yes No	Depressed mood	Yes No
Dry skin	Yes No	Difficulty sleeping	Yes No
Hives	Yes No	Eating disorder	Yes No
Itching	Yes No	Loss of appetite	Yes No
Keloid formation	Yes No	Mental or Physical abuse	Yes No
Mole(s)	Yes No	Stressors	Yes No
Rash	Yes No	Substance abuse	Yes No
Skin cancer	Yes No	Suicidal thoughts	Yes No
Skin lesion(s)	Yes No		

Immunizations

Hepatitis Vaccination: Yes No Date:______________________

Flu Vaccination: Yes No Date:______________________

Pneumonia Vaccination: Yes No Date:_______________________

Tetanus Vaccination: Yes No Date:_______________________

Colonoscopy Yes No

Date: __________________

Mammogram Yes No

Date: _________________

Lifestyle and Personal History:

I presently smoke (electronic included)	Yes No	I have smoked	Yes No
I presently use Tobacco products	Yes No	I have used tobacco products	Yes No
I use recreational drugs	Yes No	I have used recreational drugs	Yes No

I consume alcoholic beverages (amount and frequency):____

I take the following vitamins/herbal supplements (type and dosage):_______________________________

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