SOUTH SHORE COSMETIC SURGEONS
HEALTH QUESTIONNAIRE

Name: ______________________________ Date: ____________ Referred by: ______________________________

Age: ______________ Date of Birth: ____

Family Physician & Location: ____

Reason for seeing Doctor today: ____

List all medications you are taking: ____

____

ALLERGIES: **DESCRIBE REACTION**: ____

	Yes	No
Penicillin	□	□
Other Meds	□	□
____________________		
Iodine	□	□

Weight Loss: _______________ Weight Gain: ____________________________

Smoke: Yes □ No □ If yes, how much? ______________________

Have you taken any aspirin in the last two weeks? Yes □ No □

List all hospitalizations, operations (including plastic surgery) and serious injuries

Year	Hospitalization-Operation/Injury	Hospital & Location
__________	__________________________________	____
__________	__________________________________	____
__________	__________________________________	____
__________	__________________________________	____

ILLNESS and MEDICAL PROBLEMS

	Yes	No		Yes	No		Yes	No
Dizzy Spells	□	□	Pneumonia	□	□	Stomach/Duodenal Ulcer	□	□
Glaucoma	□	□	Tuberculosis	□	□	Colitis	□	□
Other Eye Problems	□	□	Other Lung Problems	□	□	Diverticulosis	□	□
Ear Trouble	□	□	High Blood Pressure	□	□	Other Bowl Problems	□	□
Sinus Trouble	□	□	Heart Attack	□	□	Hepatitis	□	□
Deafness or			Heart Murmur	□	□	Mononucleosis	□	□
Decreased Hearing	□	□	Heart Disease	□	□	Gall Bladder Trouble	□	□
Repeated Nose Bleeds	□	□	Bleeding Disorder	□	□	Stroke	□	□
Chronic Nose Obstruction	□	□	Anemia	□	□	Convulsion/Seizures	□	□
Swelling in Neck	□	□	Bleed Easily	□	□	Scarlet Fever	□	□
Asthma	□	□	Bruise Easily	□	□		□	□
Bronchitis	□	□	Ankles Swell	□	□		□	□

FAMILY HISTORY

	Yes	No		Yes	No		Yes	No
Tuberculosis	□	□	Diabetes	□	□	Cancer	□	□
Asthma	□	□	Rheumatoid Arthritis	□	□	Year & Type of Cancer & Relationship		
Glaucoma	□	□	Heart Disease	□	□	__________ ______________________		
Cancer	□	□	High Blood Pressure	□	□	__________ ______________________		
Low Blood Pressure	□	□	Arthritis	□	□	__________ ______________________		
Bleeding Rendency	□	□	Trouble with Anesthesia	□	□	__________ ______________________		
Blood Disorders (Sickle Cell Anemia, etc.)	□	□	Paralysis	□	□			

WOMEN ONLY

	Yes	No		Yes	No		Yes	No
Tender Breasts	□	□	Fibrocystic Disease	□	□	Age at 1st Pregnancy? ___________		
Discharge from Nipples	□	□	Previous Mammogram	□	□	Were children breast fed?	□	□
Lumps or recent change in size	□	□	Year _____________					
			Menstrual Problems	□	□			