GLACIER VIEW
PLASTIC SURGERY
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Confidential Health Questionnaire

Please write legibly and complete this form to the best of your knowledge.

Patient Name: ___________________________________ DOB: _____________ Age: _________

Weight: _________lbs Height: _________ Bra Size: _________ Unknown, N/A.

Primary Care Doctor: _______________________ Referring Provider: ___________________________

What pharmacy do you use? ____

Name and dosage of any medications you currently taking (Including Vitamins, Herbals, Aspirin, Motrin, Ibuprofen, Fish Oil or Aleve):

____ ____
____ ____
____ ____

Please list any known drug allergies and reactions (medications, tapes, latex or adhesives):

____ ____
____ ____

Have you been hospitalized for any reason in the past 3 months? ☐ Yes ☐ No

If Yes, Please Explain: ____

Please list all surgeries you've had, including the date: _______________________________________

____ ____
____ ____

Do you now have, or have you had in the past: please check (√) all that applies

□ Stroke
□ Thyroid Problems
□ Diabetes Mellitus or Pre-Diabetes
□ Anemia
□ Blood Disorder or Clotting Problems
□ Easy Bruising
□ Arthritis
□ Osteoporosis
□ ___________Cancer/Tumors
□ Angina or Chest Pain
□ Heart Attack
□ Heart Disease
□ Palpitations Irregular or rapid heartbeat
□ Heart murmurs
□ Asthma
□ Varicose Veins
□ Shortness of breath or wheezing
□ Sleep apnea or use a CPAP machine
□ High blood pressure
□ Stomach or duodenal ulcer
□ Stomach or intestinal bleeding
□ Hepatitis
□ Liver Problems
□ Drug or Alcohol Dependency
□ Frequent gum or nose bleeds
□ AIDS or HIV positive
□ Jaundice or liver disease
□ Mood disturbance
□ Depression
□ Anxiety
□ Eating Disorder
□ Seizures
□ Frequent heartburn or reflux
□ Fainting or dizziness
□ Nervous breakdowns
□ Immune disorders or RA / Lupus
□ Lung Disease
□ Autoimmune disease
□ COPD
□ Glaucoma
□ Kidney Problems
□ Tuberculosis
□ (DVT) Deep Vein Thrombosis
□ (PE) Pulmonary Embolism

Other: ____

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Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Partner

Number of pregnancies? ____ Number of children _____ ages: Son(s): _____Daughter(s): _____

Are you planning on having more children? ☐ Yes ☐ No

Is there any chance you are pregnant? ☐ Yes ☐ No

Has your weight been stable the last 6 months or more ☐ Yes ☐ No
Are you using a birth control method ☐Yes (which one) ______________________ ☐ No
At what age did you get your first menstruation? __________________________
Occupation: FT-PT: ___________________, Student, Self Employed-Retired-Disabled-Unemployed

Do you use tobacco products? ☐ Yes ☐ No ☐ Past
What type _____________________
How much _____________________
How many times a day ____________
When did you stop ______________

Do you use recreational drugs?
☐ Yes (Kind) __________________ ☐ No
Do you drink alcohol? ☐Yes _________ ☐No
How many a week ______________

Family Medical History: please check (√) all that applies

	Alive	Deceased	Cancer	Breast Cancer	Heart Disease	Genetic Condition	Diabetes	High Blood Pressure	Unknown	Healthy
Mother										
Father										
Brother(S)										
Sister(S)										
Son(S)										
Daughter(S)										
Maternal GM										
Maternal GF										
Paternal GM										
Paternal GF										

If (√), please explain: ____
____

Does anyone including yourself or your family history have any blood clotting problems or any reaction to anesthesia? Is so, please explain: ____

Signature ____Date____________________

Please turn this form into the front desk when completed.

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