



Cosmetic Surgery Clinics

OPERATIVE HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name _____ MR# _____

Date _____

PERSONAL INFORMATION

| | | | |
|---------------------------------------|---------------------|-------------|--|
| Name (Last, First, M.I.) | | ◆ M ◆ F | DOB (mm/dd/yyyy) |
| Street Address | | Home Phone | |
| City, State, Zip | | Work Phone | |
| SS# | Occupation/Employer | | |
| Driver's License # | Race/Ethnicity | | |
| Marital Status: | ◆ Single | ◆ Partnered | ◆ Married ◆ Separated ◆ Divorced ◆ Widowed |
| Spouse/Partner Name | DOB (mm/dd/yyyy) | | |
| Phone | Occupation/Employer | | |
| Parent/Guardian's Name (If under 18) | | | |
| Emergency Contact (Other than Spouse) | | | Relation |
| Address | | | Phone |

INSURANCE & BILLING INFORMATION

| | | | |
|--------------------------------------|-----------------|---------------------|---------|
| Billing Name (If other than Patient) | | Relation to Patient | |
| Billing Address | | Phone | |
| 1 | Insurance Co | Address | |
| | Name of Insured | Relation | Group # |
| | Effective Date | Benefit Code | ID # |
| 2 | Insurance Co | Address | |
| | Name of Insured | Relation | Group # |
| | Effective Date | Benefit Code | ID # |
| Medicare ID# | Medicaid ID# | | |
| Other Coverage | | | |

PERSONAL HEALTH

| | | |
|---|--|--------------|
| Describe your general health: ◆ Good ◆ Fair | Explain if not good: | |
| ◆ Poor | | |
| Date of last physical exam | Referred by | Office phone |
| Childhood illness: | ◆ Measles ◆ Mumps ◆ Rubella ◆ Chickenpox ◆ Polio ◆ Rheumatic Fever | |
| Immunizations: | ◆ Tetanus ◆ Hepatitis ◆ Influenza ◆ Pneumonia ◆ Chickenpox ◆ Measles, Mumps, Rubella | |

Surgeries, Hospitalizations and Complications

| Year and Hospital | Reason | Complications or After-Effects |
|-------------------|--------|--------------------------------|
| | | |
| | | |
| | | |

Patient Name _____ MR# _____
Date _____

PERSONAL HEALTH CONTINUED

Have you ever had a blood transfusion? ◆ Yes ◆ No

Please list ALL your prescribed drugs and over-the-counter drugs. Include Birth Control, Diuretics, Heart and Blood Pressure medication, Hormone Therapy, Nasal Sprays, Blood Thinners, Aspirin, Rub-On-Creams, Weight Loss medications, Laxatives, Vitamins, Inhalers, etc.

| | | |
|----|----|-----|
| 1. | 5. | 9. |
| 2. | 6. | 10. |
| 3. | 7. | 11. |
| 4. | 8. | 12. |

Allergies to medications

| Name of Drug | Reaction You Had |
|--------------|------------------|
| | |
| | |
| | |

MEDICAL HISTORY

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

| | | | |
|--------------------------|---------------|---------------|--------------------|
| ◆ Skin | ◆ Throat | ◆ Intestinal | Recent changes in: |
| ◆ Head/Neck | ◆ Lungs | ◆ Bladder | ◆ Weight |
| ◆ Ears | ◆ Chest/Heart | ◆ Bowel | ◆ Energy level |
| ◆ Nose | ◆ Back | ◆ Circulation | ◆ Ability to sleep |
| ◆ Other pain/discomfort: | | Explain: | |

DIAGNOSIS HISTORY

Mark "C" for Current Problems. Check and indicate age when you had any of the following symptoms or diseases.

| | | | |
|----------------------------|--|---------------------------------|--|
| ◆ Dizzy spells | ◆ Shortness of breath: ◆ on exertion ◆ lying flat | ◆ Gallbladder trouble | ◆ Back pain – recurrent |
| ◆ Fainting spells | ◆ High blood pressure | ◆ Jaundice/Hepatitis | ◆ Bone fracture/joint injury |
| ◆ Failing vision | ◆ Heart trouble | ◆ Sexually transmitted diseases | ◆ Osteoporosis |
| ◆ Eye Pain | ◆ Leg pain – when walking | ◆ Cancer | ◆ Tuberculosis |
| ◆ Double or blurred vision | ◆ Varicose veins/Plebitis | ◆ Chronic fatigue | ◆ Herpes |
| ◆ Hayfever/Allergies | ◆ Difficulty swallow | ◆ Diabetes | ◆ AIDS/HIV |
| ◆ Pneumonia | ◆ Heartburn | ◆ Thyroid disease | ◆ Acupuncture/tattoos |
| ◆ Bronchitis/Chronic cough | ◆ Peptic ulcer | ◆ Numbness/tingling sensations | ◆ Hair loss: ◆ progressive ◆ recent |
| ◆ Asthma/Wheezing | ◆ Abdominal pain | ◆ Headaches – frequent | ◆ Other |
| ◆ Chest pain | | ◆ Arthritis/Rheumatism | |

Explain:

WOMEN ONLY

Date of last menstruation:

Heavy periods, irregularity, spotting, pain, or discharge? ◆ Yes ◆ No

Number of pregnancies _____ Number of live births _____

Are you pregnant or breastfeeding? ◆ Yes ◆ No

Any urinary tract, bladder, or kidney infections within the last year? ◆ Yes ◆ No

Experienced any recent breast tenderness, lumps, or nipple discharge? ◆ Yes ◆ No

| | | |
|-------------------------|----------------|------------|
| Date of last mammogram? | Was it Normal? | ◆ Yes ◆ No |
| Patient Name _____ | | MR# _____ |
| Date _____ | | |

FAMILY HEALTH HISTORY

If any blood relative has suffered any of the following – please circle the number, then list the number & indicate which relative.

| | | | |
|-------------------|-------------------|----------------------|--|
| 1. Epilepsy | 8. Asthma | 15. Hypertension | |
| 2. Migraine | 9. Anemia | 16. High cholesterol | |
| 3. Mental illness | 10. Bleeds easily | 17. Alcoholism | |
| 4. Glaucoma | 11. Osteoporosis | 18. Hepatitis | |
| 5. Diabetes | 12. Arthritis | 19. Cancer | |
| 6. Thyroid | 13. Heart disease | 20. Other | |
| 7. Hayfever | 14. Stroke | | |

MENTAL HEALTH

| | |
|---|------------|
| Is stress a major problem for you? | ◆ Yes ◆ No |
| Do you feel depressed? | ◆ Yes ◆ No |
| Do you panic when stressed? | ◆ Yes ◆ No |
| Do you have problems with eating or your appetite? | ◆ Yes ◆ No |
| Do you cry frequently? | ◆ Yes ◆ No |
| Have you ever attempted suicide? | ◆ Yes ◆ No |
| Have you ever seriously thought about hurting yourself? | ◆ Yes ◆ No |
| Do you have trouble sleeping? | ◆ Yes ◆ No |
| Have you ever been to a counselor? | ◆ Yes ◆ No |
| Do you have an eating disorder? | ◆ Yes ◆ No |

HEALTH HABITS AND PERSONAL SAFETY

All questions contained in this questionnaire are optional and will be kept strictly confidential

| | | | | |
|-----------------|--|------------------------|--|--------------------------------------|
| Exercise | ◆ Sedentary (No exercise) | | | |
| | ◆ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | |
| | ◆ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 minutes) | | | |
| | ◆ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | |
| Diet | Are you dieting? ◆ Yes ◆ No | | If yes, are you on a physician prescribed medical diet? ◆ Yes ◆ No | |
| | # of meals you eat in an average day? | | | |
| | Rank salt intake | ◆ Hi | ◆ Medium | ◆ Low |
| | Rank fat intake | ◆ Hi | ◆ Medium | ◆ Low |
| | Rank carbohydrate intake | ◆ Hi | ◆ Medium | ◆ Low |
| Caffeine | ◆ None | ◆ Coffee # of cups/day | ◆ Tea # of cups/day | ◆ Soda # of cans/day |
| Alcohol | Do you drink alcohol? ◆ Yes ◆ No | | If yes, how many drinks per week? | |
| Tobacco | Do you use tobacco? ◆ Yes ◆ No | | If yes, amount per day? # of years Year quit? | |
| Drugs | Do you currently use recreational or street drugs? ◆ Yes ◆ No | | | |
| | Have you ever given yourself street drugs with a needle? ◆ Yes ◆ No | | | |
| Sex | Are you sexually active? ◆ Yes ◆ No | | Are you trying to get pregnant? ◆ Yes ◆ No | Do you practice safe sex? ◆ Yes ◆ No |
| | Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. ◆ Yes ◆ No | | | |

Do you have reason to believe that you may be at risk for this illness?

Patient Name _____ MR# _____

Date _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. _____ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

CONSENT TO RELEASE PHOTOGRAPHS

I hereby authorize Dr. _____ to release of all photographs that may be necessary for use in medical journals, internet use, marketing, plastic surgery conferences, and presentations.

MEDICARE – MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

ASSIGNMENT OF INSURANCE PATIENTS

I hereby authorize direct payment of surgical/medical benefits to Dr. _____ for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. _____ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Please sign below to certify that all information provided on this Operative History Questionnaire (Pages 1 thru 4) is true and accurate to the best of your knowledge:

Patient Name (please print) _____ Date _____

Parent/Guardian (please print) _____ Signature _____

A photocopy of these assignments shall be as valid as the original

PHYSICIAN NOTES – SHADED SECTION BELOW FOR OFFICE USE ONLY

PHYSICAL EXAM

| Height | Weight | Recent Wt Change +/- | Blood Pressure |
|--------|--------|----------------------|----------------|
|--------|--------|----------------------|----------------|

A/P

Physician Signature

Date