PLASTIC SURGEONS
OF AKRON

History and Health Questionnaire

Name: _____ Date: _____ Chart #: _____

Please check if Applicable:

HAVE YOU HAD:

- Anemia ☐
- Asthma ☐
- Bleeding Problems ☐
- Cancer ☐
- Cold Sores ☐
- Diabetes ☐
- Enlarged Glands ☐
- Fainting Spells ☐
- Hayfever ☐
- Heart Disease ☐
- High Blood Pressure ☐
- Low Blood Pressure ☐
- Paralysis ☐
- Phlebitis ☐
- Seizures ☐
- Thrombosis ☐
- Thyroid (Overactive) ☐
- Thyroid (Underactive) ☐
- Varicose Veins ☐

FAMILY HISTORY:

- Bleeding Problems ☐
- Cancer ☐
- Diabetes ☐
- Heart Disease ☐

PROBLEMS WITH EYES:

- Diseases ☐
- Dryness ☐
- Excessive Tearing ☐
- Impaired Sight ☐
- Injury ☐

PROBLEMS WITH NOSE:

- Injury ☐
- Nose Bleeds ☐
- Sinuses ☐

Any decreased sensation in any part of the body? If yes, please explain: _____

PLEASE LIST ALL MEDICATIONS THAT YOU USE REGULARLY:

Allergies:

- Adhesive Tape ☐
- Antitoxin ☐
- Aspirin ☐
- Codeine ☐
- Demerol ☐
- Latex ☐
- Morphine ☐
- Mycins ☐
- Penicillin ☐
- Serums ☐
- Sulfa Drugs ☐
- Tetanus ☐
- Valium ☐

Any other drugs or anti-biotics, etc: _____

Have you been hospitalized for any medical illness or surgical procedure? Yes☐ No☐
If yes, please explain: _____

DO YOU USE:

- Aspirin/Blood Thinners ☐
- Hormone Replacements ☐
- Sedatives ☐
- Sleeping Pills ☐
- Tranquilizer ☐
- Vitamin E ☐

DO YOU SMOKE? ☐ Yes ☐ No **If so, how many packs per day?** _____

Do you currently use any Herbal, Vitamin Supplements or Weight Control Substances? Yes☐ No☐
If yes, please specify: _____

Have you had a PAP Smear within the last three years? Yes☐ No☐
When was your last Mammogram? Date: _____
Date of your last PHYSICAL EXAM? _____
Please list current height and weight: Height: _____ Weight: _____

I attest that the above information is true and correct _____
Signature