**PLASTIC SURGERY**
Wright State Physicians

**Miami Valley Hospital**
30 E. Apple Street, Suite 2200 ▪ Dayton, OH 45409-2939
**Tel** 937.208.3999 ▪ **Fax** 937.208.3682
wrightstatephysicians.org/plastic

# Patient History Form

Date ______________________________

Patient Name ______________________________ DOB ______________________________
Describe your main problem ______________________________
Where is your problem located? ______________________________
How severe is your problem? ______________________________
How long have you had this problem? ______________________________
When does this problem occur? ______________________________
Where were you when this problem started? ______________________________
What other things happen with this problem? ______________________________

| List previous Hospitalizations/Surgeries/Serious Injuries | When? |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## List Medications you are currently taking

______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________

## Have you ever had the following?

| | | |
|---|---|---|
| Diabetes | YES | NO |
| Hypertension | YES | NO |
| Cancer | YES | NO |
| Stroke | YES | NO |
| Heart trouble | YES | NO |
| Arthritis/Gout | YES | NO |
| Convulsions | YES | NO |
| Bleeding tendencies | YES | NO |
| Acute infections | YES | NO |
| Venereal disease | YES | NO |
| Hereditary defects | YES | NO |

## Patient Social History

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Use of alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily ______________
Use of tobacco ☐ Never ☐ Previously but quit ☐ Current packs per day ______
Use of drugs ☐ Never ☐ Type/Frequency ______________________________
Allergies ☐ None ☐ Yes to medications ______________________________
☐ Yes to other ______________________________

## Family Medical History

| | Age | Diseases | If Deceased, Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Siblings | | | |
| | | | |
| | | | |
| Spouse | | | |
| Children | | | |
| | | | |
| | | | |

OVER

Patient Signature________________________ Physician Signature________________________

## Please answer all questions

**Have you ever had any of the following during the past three months?**

### Constitutional

| | | |
|---|---|---|
| Good general health lately | No | Yes |
| Recent weight change | No | Yes |
| Fever | No | Yes |
| Fatigue | No | Yes |
| Headaches | No | Yes |

### Eyes

| | | |
|---|---|---|
| Eye disease or injury | No | Yes |
| Wear glasses/contact lenses | No | Yes |
| Blurred or double visition | No | Yes |
| Glaucoma | No | Yes |

### ENT

| | | |
|---|---|---|
| Hearing loss | No | Yes |
| Ringing in the ears | No | Yes |
| Earaches or drainage | No | Yes |
| Sinus problems | No | Yes |
| Nose bleeds | No | Yes |
| Mouth sores | No | Yes |
| Bleeding gums | No | Yes |
| Bad breath or bad taste | No | Yes |
| Sore throat or voice change | No | Yes |
| Swollen glands in neck | No | Yes |

### Cardiovascular

| | | |
|---|---|---|
| Heart trouble | No | Yes |
| Chest pains | No | Yes |
| Sudden heart beat changes | No | Yes |
| Swelling of feet, ankles or hands | No | Yes |

### Respiratory

| | | |
|---|---|---|
| Frequent coughing | No | Yes |
| Spitting up blood | No | Yes |
| Shortness of breath | No | Yes |
| Asthma or wheezing | No | Yes |

### Gastrointestinal

| | | |
|---|---|---|
| Loss of appetite | No | Yes |
| Change in bowel movements | No | Yes |
| Nausea or vomitting | No | Yes |
| Frequent diarrhea | No | Yes |
| Painful bowel movement/constipation | No | Yes |
| Blood in stool | No | Yes |
| Stomach pain | No | Yes |

### Genitourinary

| | | |
|---|---|---|
| Frequent urination | No | Yes |
| Burning or painful urination | No | Yes |
| Blood in urine | No | Yes |
| Change force of strain when urinating | No | Yes |
| Incontinence or dribbling | No | Yes |
| Kidney stones | No | Yes |
| Sexual difficulty | No | Yes |
| Male - testicle pain | No | Yes |
| Female - pain with periods | No | Yes |
| Female - irregular periods | No | Yes |
| Female - vaginal discharge | | |

Female - # pregnancies ______ # miscarriages ______

Female - date of last pap smear ____________________

Female - findings of last pap smear ☐ Normal ☐ Abnormal

### Musculoskeletal

| | | |
|---|---|---|
| Joint Pain | No | Yes |
| Joint Stiffness or swelling | No | Yes |
| Weakness of muscles or joints | No | Yes |
| Muscle pain or cramps | No | Yes |
| Back pain | No | Yes |
| Cold extremities | No | Yes |
| Difficulty in walking | No | Yes |

### Skin

| | | |
|---|---|---|
| Rash or itching | No | Yes |
| Change in skin color | No | Yes |
| Change in hair or nails | No | Yes |
| Varicose veins | No | Yes |
| Breast pain | No | Yes |
| Breast lump | No | Yes |
| Breast discharge | No | Yes |

### Neurological

| | | |
|---|---|---|
| Frequent or recurring headaches | No | Yes |
| Light headed or dizzy | No | Yes |
| Convulsions or seizures | No | Yes |
| Numbness or tingling sensations | No | Yes |
| Tremors | No | Yes |
| Paralysis | No | Yes |
| Stroke | No | Yes |
| Head injury | No | Yes |

### Psychiatric

| | | |
|---|---|---|
| Memory loss or confusion | No | Yes |
| Nervousness | No | Yes |
| Depression | No | Yes |
| Sleep problems | No | Yes |

### Endocrine

| | | |
|---|---|---|
| Grandular or hormone problem | No | Yes |
| Thyroid disease | No | Yes |
| Diabetes | No | Yes |
| Excessive thirst or urination | No | Yes |
| Heat or cold intolerance | No | Yes |
| Dry skin | No | Yes |
| Change in hat or glove size | No | Yes |

### Hematologic/Lymphatic

| | | |
|---|---|---|
| Slow to heal after cuts | No | Yes |
| Easily bruise or bleed | No | Yes |
| Anemia | No | Yes |
| Phlebitis | No | Yes |
| Past transfusion | No | Yes |
| Enlarged Glands | No | Yes |