

AESTHETIC & PLASTIC SURGERY INSTITUTE

University of California, Irvine

HISTORY AND PHYSICAL

Patient Name: _____ Email: _____

Address: _____ City _____ Zip _____

Parent or Guardian Name: _____

Patient Birth Date: _____ Age: _____

Home Telephone Number: (____) _____ Best time to call: _____

Alternative Phone Number: (____) _____

Primary Care Doctor: _____

Address: _____ City _____ Zip _____

Office Telephone Number: (____) _____

Referral Source: UCI Web Plastic Surgery Web Magazine Friend MD

Please Indicate Name/Address: _____

Present Illness:

What brought you to the office today? _____

Who referred you to our office? _____

Describe the problem (painful, painless, sharp, dull, etc.) _____

Severity of the problem (Scale of 1-10) _____

When did you first notice the problem? _____

Does anything make the problem better or worse? _____

How long does the problem last? _____

Family History – Do you have a family history of any medical problems?

Hypertension	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Seizure	Bleeding Problems
Heart Attack	Liver Disease	Stroke
Emphysema	Hepatitis	Other _____

Skin

Basal Cell Skin Cancer _____ Yes _____ No

Melanoma _____ Yes _____ No

Comments: _____

Eyes

Cataracts _____ Yes _____ No

Glaucoma _____ Yes _____ No

Comments: _____

Social History:

Occupation: _____ Marital Status: _____

Name: _____ DOB: ___/___/___ Age: ___ Gender: M ___ F ___ Wt: ___ Ht: ___
 Primary MD: _____ Last Visit: _____ Surgeon: _____
 Previous Surgery at UCIMC? Y ___ N ___ Best time to call: _____ Best number to reach you: (____) _____
 Best time for Pre Op Clinic Visit: _____ Pre Op Phone interview: _____
 Will you be arriving from out of the area? Y ___ N ___ If yes, from where? _____

Patient Questionnaire

Please answer the following YES or NO questions to the best of your ability. If you are unsure, or have comments, please note the question in the comments at the end of each section.

CARDIOVASCULAR	YES	NO	Year	Hem/Onc/Infectious cont.	YES	NO	Year	NEUROPSYCHIATRY	YES	NO	Year
1. High Blood Pressure	_____	_____	_____	27. Radiation therapy	_____	_____	_____	50. Stroke	_____	_____	_____
2. Heart Attack	_____	_____	_____	28. Chemotherapy	_____	_____	_____	51. Seizure	_____	_____	_____
3. Angina/chest pain	_____	_____	_____	Type? _____	_____	_____	_____	52. Fainting	_____	_____	_____
4. Heart Bypass surgery	_____	_____	_____	Comments: _____	_____	_____	_____	53. Dizziness	_____	_____	_____
5. Pacemaker or Defibrillator*	_____	_____	_____		_____	_____	_____	54. Headache	_____	_____	_____
*If "YES," initiate pacemaker protocol								55. Double Vision	_____	_____	_____
6. Congestive Heart Failure/ Fluid in lungs	_____	_____	_____	GASTROINTESTINAL	YES	NO	Year	56. Depression	_____	_____	_____
7. Palpitations/Irregular heartbeat	_____	_____	_____	29. Alcoholic liver disease	_____	_____	_____	57. Anxiety	_____	_____	_____
8. Heart murmur	_____	_____	_____	30. Acid Reflux	_____	_____	_____	58. Psychiatric Care	_____	_____	_____
9. Do you exercise?	_____	_____	_____	31. Heartburn	_____	_____	_____	Comments: _____	_____	_____	_____
How often? _____				32. Hepatitis	_____	_____	_____				
Type? _____				33. Jaundice	_____	_____	_____				
10. Have you ever seen a Cardiologist?	_____	_____	_____	34. Alcohol use?	_____	_____	_____	*FOR PEDIATRIC PATIENTS ONLY*	YES	NO	
Who? _____				Amount: _____				1. Was child born prematurely?	_____	_____	
Where? _____				35. Recreational drugs	_____	_____	_____	If YES, how many weeks premature were they? _____			
Comments: _____				Comments: _____				2. Problems noted at birth?	_____	_____	
								If YES, please explain: _____			
				URINARY/REPRODUCTIVE	YES	NO	Year				
RESPIRATORY	YES	NO	Year	36. Urinary/Kidney disease	_____	_____	_____				
11. Abnormal Chest X-ray	_____	_____	_____	37. Dialysis	_____	_____	_____				
12. Asthma	_____	_____	_____	38. Hemodialysis	_____	_____	_____				
13. Bronchitis	_____	_____	_____	39. Peritoneal Dialysis	_____	_____	_____				
14. Emphysema	_____	_____	_____	40. If Female, could you be pregnant?	_____	_____	_____				
15. Recent Respiratory Infection (within last 4 weeks)	_____	_____	_____	41. Date of last menstrual period: _____	_____	_____	_____	1. _____	_____	_____	Date
16. Shortness of Breath with Exertion/Activity	_____	_____	_____	Comments: _____				Complications: _____			
17. Can you lay flat on your back?	_____	_____	_____					2. _____	_____	_____	Date
18. Sleep Apnea	_____	_____	_____	ENDOCRINE	YES	NO	Year	Complications: _____			
19. Current Cough	_____	_____	_____	42. Diabetes	_____	_____	_____	3. _____	_____	_____	Date
20. Cough with Sputum Production	_____	_____	_____	43. Thyroid Disease	_____	_____	_____	Complications: _____			
21. Do you smoke?	_____	_____	_____	44. Taken Steroids in the past year?	_____	_____	_____	4. _____	_____	_____	Date
How many years? _____				Comments: _____				Complications: _____			
Comments: _____								5. _____	_____	_____	Date
				MUSCULOSKELETAL	YES	NO	Year	Complications: _____			
HEMATOLOGIC/ONCOLOGIC/ INFECTIOUS	YES	NO	Year	45. Arthritis	_____	_____	_____	6. _____	_____	_____	Date
22. Bleeding tendency (gums, nose)	_____	_____	_____	46. Rheumatoid	_____	_____	_____	Complications: _____			
23. Easy bruising	_____	_____	_____	47. Neck, Back, Arm, Leg Problems?	_____	_____	_____	7. _____	_____	_____	Date
24. Anemia	_____	_____	_____	48. Herniated disc	_____	_____	_____	Complications: _____			
25. Sickle Cell disease	_____	_____	_____	49. Sciatica	_____	_____	_____	8. _____	_____	_____	Date
26. Blood clots in legs or lungs	_____	_____	_____	Comments: _____				Complications: _____			

Patient Name _____

FAMILY HISTORY

1. Do you have any **personal** history of anesthetic complications? **YES NO**

If YES, please explain: _____

2. Is there a **family** history of anesthetic complications? **YES NO**

If YES, please explain: _____

BLOOD

1. Do you have any reason why you would refuse blood or blood products? **YES NO**

If YES, please explain: _____

2. Do you have an Advance Directive? **YES NO**

If YES, please bring on date of surgery.

MEDICATIONS (include over-the-counter and herbal)	Dose	Frequency	ALLERGIES (list all)	Reaction
1.			1.	
2.			2.	
3.			3.	
4.			4.	
5.			5.	
6.			6.	
7.			7.	
8.			8.	
9.			9.	
10.			10.	
11.			11.	
12.			12.	
13.			13.	
14.			14.	
15.			15.	
16.			16.	
17.			17.	
18.			18.	
19.			19.	
20.			20.	

Do you have any **comments or concerns** you would like to share with our staff? **YES NO**

PATIENT or GUARDIAN (PRINT NAME): _____

SIGNATURE: _____

DATE: _____

X

OFFICE USE ONLY

QUESTIONNAIRE REVIEWED BY: _____

Please complete BOTH pages
NOT A PART OF PERMANENT RECORD