THOMAS P. STERRY, M.D., P.C.

DIPLOMATE AMERICAN BOARD OF PLASTIC SURGERY

Detailed Health Questionaire

Patient information

Patient: _____

Birthdate: _____ Age: _____ Weight: _____ lbs

What surgery are you considering? _____ Height: _____ ft _____ in

Conditions

DO YOU NOW OR HAVE YOU EVER HAD... (You must check an answer for each individual item)

Heart Trouble	○ Yes ○ No	Glaucoma or Eye Problems	○ Yes ○ No
Heart Attack	○ Yes ○ No	Visual Disturbances	○ Yes ○ No
Heart Pain	○ Yes ○ No	Error in Refraction	○ Yes ○ No
Palpitation or Irregular Pulse	○ Yes ○ No	Other Eye Problems	○ Yes ○ No
Extra Heart Beats	○ Yes ○ No	Hepatitis	○ Yes ○ No
Stroke	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No
Hypertension	○ Yes ○ No	Gallstones or Gallbladder Trouble	○ Yes ○ No
Blood Pressure Abnormalities	○ Yes ○ No	Cirrhosis of the Liver	○ Yes ○ No
Abnormal EKG	○ Yes ○ No	Alcoholism or Drug Dependency	○ Yes ○ No
Rheumatic Fever	○ Yes ○ No	Esophageal Varices	○ Yes ○ No
Dropsy or Heart Failure	○ Yes ○ No	Frequent Indigestion	○ Yes ○ No
Digitalis Treatment	○ Yes ○ No	Ulcers	○ Yes ○ No
Shortness of Breath	○ Yes ○ No	Gastritis	○ Yes ○ No
Chest Pain	○ Yes ○ No	Colitis	○ Yes ○ No
Asthma	○ Yes ○ No	Problem Constipation	○ Yes ○ No
Bronchitis	○ Yes ○ No	Vomiting Blood	○ Yes ○ No
Pneumonia	○ Yes ○ No	Tarry or Bloody Bowel Movements	○ Yes ○ No
Tuberculosis	○ Yes ○ No	Hemorrhoids	○ Yes ○ No
Smokers Cough	○ Yes ○ No	Goiter or Thyroid Disorders	○ Yes ○ No
Emphysema	○ Yes ○ No	Diabetes	○ Yes ○ No
Coughing or Spitting of Blood	○ Yes ○ No	Skin Disorders	○ Yes ○ No
Hay Fever	○ Yes ○ No	Arthritis	○ Yes ○ No
Major Allergies	○ Yes ○ No	Fracture of Neck or Spine	○ Yes ○ No
Palsy or Paralysis	○ Yes ○ No	Bleeding Tendency or Disorder	○ Yes ○ No
Nervous Breakdown	○ Yes ○ No	Abnormal Bleeding after Tooth Extraction	○ Yes ○ No
Nervous Disorder	○ Yes ○ No	Airway Obstruction (Nasal)	○ Yes ○ No
Insomnia	○ Yes ○ No	Breast Cysts, Tumors, Abscesses	○ Yes ○ No
Drug Habit	○ Yes ○ No	Nipple Discharge (Apart from Normal Lactation)	○ Yes ○ No
Self-Destructive Tendencies	○ Yes ○ No	Kidney Disorder	○ Yes ○ No
Psychiatric Hospitalization or Care	○ Yes ○ No	Blood Transfusion	○ Yes ○ No
Thyroid Problems	○ Yes ○ No	Seizures or convulsions or fainting spells	○ Yes ○ No
Kidney or Renal Disease	○ Yes ○ No	Black outs	○ Yes ○ No

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Conditions continued...

DO YOU NOW OR HAVE YOU EVER HAD... (You must check an answer for each individual item)

Heart murmur	○ Yes ○ No	Dentures, bridges, capped teeth or crowns	○ Yes ○ No
Piercing other than the ears	○ Yes ○ No	Loose teeth	○ Yes ○ No
Positive blood test for: HIV, AIDS, Hepatitis	○ Yes ○ No	Cosmetic bonding to teeth	○ Yes ○ No
Missed or irregular last menstrual period	○ Yes ○ No	Any family members with bleeding problems	○ Yes ○ No
Family history of cancer, heart trouble, stroke	○ Yes ○ No	Any family members with anesthesia problems	○ Yes ○ No

Surgeries and hospitalizations

Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:

SURGICAL OPERATIONS (include where, when and why for each surgery):

PAST MEDICAL HISTORY (Please list any conditions. Have you ever been "sick"?):

Medications

Please list all present medications, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. Include over-the-counter medications.

1. Do you have an allergic reaction to any medication? ○ Yes ○ No Which? _____

2. Do you react abnormally to any medication? ○ Yes ○ No Which? _____

3. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?
○ Yes ○ No If yes, when and where? _____

4. Have you ever been on cortisone or steroid treatment? ○ Yes ○ No When? _____

Medical status

5. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?
Yes No If so, how much? _____

6. Do you smoke? Yes No If so, how much? _____ For how long? _____

7. Are you pregnant? Yes No

8. How many pregnancies? _____ Births? _____ Breast fed? Yes No How long? _____

9. Who is your personal physician, if any? _____

Please list all physicians presently caring for you.

10. Have you had any recent blood work done? Yes No Where? _____

Acknowledgement

Email address: _____

By signing below I agree that the above information is complete and accurate to the best of my knowledge.

Patient's Signature: _____ **Date:** _____