The Center for Facial Plastic Surgery

Ali Sepehr, MD

PATIENT HEALTH SURVEY

NAME_____ DATE OF BIRTH: _____ M___ F___ DATE_____

REASON FOR YOUR VISIT TODAY (MAIN SYMPTOMS):

_____
_____
_____
_____

HOW LONG HAVE YOU HAD THE SYMPTOMS:

_____
_____

HAVE YOU HAD ANY TREATMENT:

_____
_____
_____

HISTORY OF PAST ILLNESS: Have you had

Childhood:

☐Measles ☐Mumps ☐Chicken Pox
☐Congenital Abnormalities ☐Rheumatic fever or heart disease

ADULT:

☐Asthma	☐High Blood Pressure	☐Cancer (Site_____)
☐Diabetes	☐Ulcer or Gastritis	☐Thyroid problems
☐Tuberculosis	☐Kidney Problem	☐Liver Problems
☐Blood Problem	☐Venereal Disease	☐Heart Failure
☐Heart Attack	☐Abnormal Heart Rhythm	

Have you had any serious illness? No Yes
Have you ever had a transfusion? No Yes
Have you ever been hospitalized or been under medical care for very long? No Yes
If Yes, for what reason? _____
_____
OTHER:_____

OPERATIONS:

Have you ever had surgery? No Yes

LIST: _____
_____
_____
_____

ALLERGIES (to medications, seasonal, food, etc):

_____
_____
_____

MEDICATIONS:_____
_____
_____

SOCIAL HISTORY:

Circle One: Single Married Separated Divorced Widowed Significant Other

With whom do you live? _____
Recreational Drug Usage? No Yes
Foreign travel within last year _____
Coffee_____ Tea_____ Cola's _____ (per day)
Alcoholic Beverages: Never___ <1 per week ___ 1-5 per week___ Other_____
Tobacco: ☐Never smoked ☐Quit____ years ago ☐Years Smoked____☐ Packs per day___

Education: (Years)

Grade School _____ College _____ Postgraduate _____

Family History:	Age	Health Status	If Deceased, Age at death	Cause of Death
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Name_____ **Date of Birth**_____ **M/F**_____ **Date**_____

CIRCLE NO OR YES FOR THOSE THAT APPLY

SYSTEMIC REVIEW: Do you have any of the following?

General: Maximum weight _____

Minimum weight _____

Recent weight change?	No	Yes
Have you been in good general health most of your life?	No	Yes

Have you recently had?

☐Weakness ☐Fever ☐Chills ☐Night Sweats
☐Fainting ☐Problems Sleeping

Skin:

Skin Disease	No	Yes
Jaundice	No	Yes
Hives, eczema or rash	No	Yes

Head-Eyes-Ears-Nose-Throat (cont'd):

Dry eyes or mouth	No	Yes
Bleeding Gums – Frequent or Constant	No	Yes
Blurred Vision	No	Yes
Sneezing or runny nose	No	Yes
Nosebleeds – Frequent	No	Yes
Chronic sinus trouble	No	Yes
Ear disease	No	Yes
Impaired hearing	No	Yes
Dizziness or sensation of room spinning	No	Yes
Frequent or severe headaches	No	Yes

Respiratory:

Asthma or Wheezing	No	Yes
Difficulty breathing	No	Yes
Any trouble with lungs	No	Yes
Cough up blood (ever)	No	Yes

Cardiovascular:

Chest pain, pressure, or tightness	No	Yes
Shortness of breath with walking or lying down	No	Yes
Difficulty walking two blocks	No	Yes
Palpitations	No	Yes
Sweating of hands, feet or ankles	No	Yes
Awakening in the night smothering	No	Yes
Heart murmur	No	Yes

Gastrointestinal:

Vomiting of blood or food	No	Yes
Change in appetite	No	Yes
Hepatitis/Jaundice	No	Yes
Bleeding with bowel movements	No	Yes
Black stools	No	Yes
Recent change in bowel habits	No	Yes
Frequent diarrhea	No	Yes
Heartburn or indigestion	No	Yes
Cramping or pain in the abdomen	No	Yes
Does food stick in throat	No	Yes

Endocrine:

Hormone therapy	No	Yes
Any change in hat or glove size	No	Yes
Any change in hair growth	No	Yes
Have you become colder than before- or skin become dryer	No	Yes

Locomotor-Musculoskeletal:

Stiffness or pain in joints (check all that apply)

☐Toes ☐Hands ☐Wrist ☐Neck ☐Shoulders
☐Hip ☐Elbows ☐Foot ☐Temporomandibular - joint
☐Knee ☐Finger ☐Back

Weakness of muscles or joints	No	Yes
Any difficulty walking	No	Yes
Have you ever had counseling for your mental health?	No	Yes
Do you ever have, or have had, fainting spells?	No	Yes
Convulsions	No	Yes
Paralysis	No	Yes
Problem with coordination	No	Yes
Depression Symptoms (difficulty sleeping, loss of appetite loss of interest in activities, feelings of hopelessness)	No	Yes
Are you slow to heal after cuts?	No	Yes
Anemia	No	Yes
Phlebitis or Blood Clots in veins	No	Yes
Have you had difficulty with bleeding excessively after tooth extraction or surgery?	No	Yes
Have you had abnormal bruising or bleeding?	No	Yes

Source of Information, if other than patient (PRINT AND SIGN):_____

_____

Signature of Patient (or Patient's Representative)

_____ _____

Print Patient or Patient's Representative's name **Date**