

## MEDICAL HISTORY QUESTIONNAIRE

Please answer the following questions fully.

Date \_\_\_\_\_

1- Full Name

2- Sex:

Male \_\_\_\_\_ Female \_\_\_\_\_

3- Age \_\_\_\_\_

4- Height \_\_\_\_\_ Weight \_\_\_\_\_

5- Marital Status

Single \_\_\_\_\_ Married \_\_\_\_\_

6- Occupation

7- What type of surgery or treatment are you interested in (please be as specific as possible)?

8- Reason you wish to have this surgery:

9- Have you had previous surgery?

Yes \_\_\_\_\_ No \_\_\_\_\_

10- If yes, what procedure did you have?

11- Were you satisfied with the results?

Yes \_\_\_\_\_ No \_\_\_\_\_

12- Please list the previous surgeries with dates:

13. Do you suffer from any chronic illnesses (diabetes, cancer etc...)?

14-How is your general health?

Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair Poor \_\_\_\_\_

15- Please mark with an X on the right side of the place in your body where you have had any problems or illnesses.

Brain \_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Nose \_\_\_\_\_ Chest \_\_\_\_\_  
Throat \_\_\_\_\_ Neck \_\_\_\_\_ Lungs \_\_\_\_\_ Heart \_\_\_\_\_ Legs \_\_\_\_\_  
Arms \_\_\_\_\_ Kidney \_\_\_\_\_ Liver \_\_\_\_\_ Stomach \_\_\_\_\_ Cataracts \_\_\_\_\_  
Bladder \_\_\_\_\_ Intestines \_\_\_\_\_ Nervous System \_\_\_\_\_  
Reproductive System \_\_\_\_\_

16- General Allergies (specify)

17- Allergies to medicines (specify)

18- Any negative experience with anesthetics?

If yes, please specify:

19- Medicines you presently take:

20- Do you use tobacco? If so what form?

21- Alcohol intake:

None \_\_\_\_\_ Daily \_\_\_\_\_ Occasionally \_\_\_\_\_

22- How does your skin scar?

Okay \_\_\_\_\_ Heavy \_\_\_\_\_ Keloid \_\_\_\_\_

23- Have you seen a psychiatrist in the last five years?

If so, please explain

Please list any specific comments or information you would like to share with us about your health and medical history: