Plastic Surgery Associates, J. Barry Bishop, M. D. **MEDICAL QUESTIONNAIRE:**

Date: _____ ***Patient Name:*** _____

CHIEF COMPLAINT/ REASON FOR VISIT: _____

OTHER DOCTORS YOU HAVE SEEN FOR THIS CONDITION/CONCERN: _____

Please check additional areas of concern that you would like to discuss with Dr. Bishop:

Body:	**Face & Neck:**	**Other:**
☐ Abdomen	☐ Face/Forehead	☐ Brown Spots/age spots/freckles
☐ Breasts/Chest	☐ Eyebrow(s)	☐ Mole(s)
☐ Arms	☐ Eyelids	☐ Scar
☐ Thighs	☐ Neck	☐ Skin Care Products
☐ Buttocks	☐ Lips	☐ Length/Fullness of Eyelashes
☐ Back	☐ Chin/cheek procedures	_____
☐ Hands/Fingers	☐ Earlobes	_____

SERIOUS MEDICAL PROBLEMS: (please list)

Current Medications:

	Name	Dose	How Often	Date Last Taken
1.				
2.				
3.				
4.				
5.				

Do you take Aspirin on a regular basis? NO YES
Do you have a Pacemaker? NO YES

ALLERGIES:

Are you allergic to any medication? NO YES If so, list _____
What type of reaction do you have? (Please Circle)
FLUSHING RASH DIZZINESS HIVES SWELLING LOSS OF CONSCIOUSNESS OTHER
Do medications have an unusual effect on you: NO YES If yes, what effect? _____
Are you allergic to adhesive tape? NO YES
Are you allergic to Iodine? NO YES
Please list other allergies: _____

HABITS:

Do you have alcoholic beverages more than 2-3 times per week? NO YES If yes, how many per day? _____
Do you smoke? NO YES Please circle: Cigarettes Cigars Pipe If yes, how many per day? _____

PAST SURGICAL HISTORY:

	Date	Operation	Surgeon	Hospital/Office
1.				
2.				
3.				
4.				
5.				

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PAST MEDICAL HISTORY: ***Have you ever had any of the following:***

Heart Disease	NO	YES	Heart Attack	No	YES	Cancer	No	Yes
Arthritis	NO	YES	Glaucoma	NO	YES	Leukemia	NO	YES
Rheumatic Fever	NO	YES	Asthma	NO	YES	Mitral Valve Prolapse	NO	YES
Anemia	NO	YES	AIDS/HIV	NO	YES	High Blood Pressure	NO	YES
Tuberculosis	NO	YES	Stroke	NO	YES	Drug Addiction	NO	YES
Diabetes	NO	YES	Hepatitis	NO	YES	Emphysema	NO	YES

PLEASE ELABORATE ON ANY "YES" ANSWERS: _____

_____

REVIEW OF SYSTEMS: ***Do you now have or have you had within the past year any of the following:***

Weight Change	NO	YES	Chest Pain	NO	YES	Stomach Ulcer	NO	YES
Obesity	NO	YES	Shortness of Breath	NO	YES	Kidney Disease	NO	YES
Depression	NO	YES	Fainting	NO	YES	Thyroid Disease	NO	YES
Other Mental Disease	NO	YES	Rapid Heartbeat	No	YES	Jaundice	NO	YES
Suicidal Tendencies	NO	YES	Circulatory Disease	NO	YES	Swollen Lymph Nodes	NO	YES
Frequent Headaches	NO	YES	Phlebitis	NO	YES	Urinary Infection	NO	YES
Easy Bleeding	NO	YES	Lung Disease	NO	YES	Chronic Diarrhea	NO	YES
Easy Bruising	NO	YES	Bronchitis	NO	YES	Joint or Muscle Pain	NO	YES
Skin Rash	NO	YES	Chronic Cough	NO	YES	Nerve/Muscle Disease	NO	YES
Dry Eyes	NO	YES	Ear Condition	NO	YES	Throat Condition	NO	YES

PLEASE ELABORATE ON ANY "YES" ANSWERS: _____

_____

FAMILY HISTORY: AGE DECEASED YES NO CAUSE OF DEATH

Father _____

Mother _____

Brother/Sister _____

Has anyone in your family had a tendency to bleed extensively?	**NO**	**YES**
Has anyone in your family had an unusual reaction to anesthesia?	**NO**	**YES**
Has anyone in your family had unexplained fevers following surgery?	**NO**	**YES**
Have you ever had a blood transfusion?	**NO**	**YES**
Do you have any metal in your body?	**NO**	**YES**

Women only:

Age period began: _____ Number of pregnancies/deliveries: _____ Did you breast feed? NO YES

Date of last mammogram: _____ Do you perform regular self-examinations? NO YES

Do you have a breast lump or any discharge? NO YES If yes, please explain _____

Do you take Oral Contraceptives? NO YES Is there any possibility you are pregnant at this time? NO YES

"I verify that the above information is true and accurate to the best of my knowledge."

Patient Signature or Parent/Guardian of a Minor: _____

J. Barry Bishop, M.D. _____ **Date:** _____