MARYLAND PLASTIC SURGERY
MEDICAL SPA & COSMETIC SURGERY CENTER

Today's Date: _____

CONFIDENTIAL QUESTIONAIRE

Name: _____ **SS#** _____ **Age:** _____

Consult for: ☐ Face ☐ Breast ☐ Body **Preference:** ☐ Surgical ☐ Non-Surgical

Specific Reason for Consult: _____

DESCRIPTION OF YOUR CONCERN / PROBLEM: Please list each of your concerns in as much detail as possible. Include the date when the concern first became apparent.

_____

_____

_____

ALLERGIC REACTIONS: Do *not* include seasonal allergies (e.g. hayfever, pollen).

DRUG ALLERGY (e.g. Penicillin, Sulfa)	REACTION

LATEX ALLERGY ☐ Yes ☐ No _____

MEDICATIONS: Include all prescription medications, over-the-counter medications (e.g. aspirin, ibuprofen), vitamins and herbal supplements (e.g. Echinacea, St. John's Wort). Continue on a separate sheet, if necessary.

MEDICATION	Dose (mg)	Times Daily	Date Started

HOSPITALIZATIONS: List all hospitalizations (include any surgeries and ER visits).

Date	Hospital	Reason for Hospitalization	Physician

MEDICAL HISTORY:

	Date Diagnosed	Details
Anesthesia Difficulties		
Cancer – (Skin, Breast, Other)		
Connective Tissue Disorder		
Diabetes		
Digestive Disorder		
Glaucoma		
Heart Disease		
High Cholesterol		
High Blood Pressure		
Immune Disorder (HIV, Lupus, Myasthenia)		
Kidney Disease		
Liver Disease (Hepatitis)		
Lung Disease (Asthma, Emphysema)		
Muscle Disease / Weakness		
Psychiatric (Bipolar, Schizophrenia)		
Sleep Apnea		
Skin Lesions		
Other:		
Other:		

FAMILY HISTORY:

Children (age & sex): _____ (M/F) _____ (M/F) _____ (M/F) _____ (M/F) _____ (M/F)

	Father	Mother	Grandparent	Sibling	Children
Bleeding Disorder					
Cancer – Breast					
Cancer - Skin					
Cancer – Other:					
Connective Tissue Disorder					
Diabetes					
Heart Disease					
High Cholesterol					
Malignant Hyperthermia					
Other:					

SOCIAL AND WELLNESS HISTORY:

With whom do you live? ☐ Alone ☐ Spouse ☐ Friend ☐ Parent/Children

Have you ever been a party to a lawsuit? ☐ No ☐ Civil Matter ☐ Malpractice ☐ Other

In general, your anxiety level is: ☐ Low ☐ Medium ☐ High

Tobacco use (typical): _____ Packs/day Years of use: _____

Alcohol use (average): _____ Drinks per ☐ Day ☐ Week ☐ Month

Caffeine use (daily): _____ Cups/day ☐ Coffee ☐ Tea ☐ Soda

Comment on any recent weight gain / loss: _____

Describe your exercise program and regularity: _____

List your hobbies: _____

WOMEN:

Age of first menses: _____ Pregnancies: _____ Live births: _____

Currently pregnant: ☐ No ☐ Yes Currently lactating: ☐ No ☐ Yes

Monthly self breast exam: ☐ No ☐ Yes

Last mammogram: _____ (date) ☐ Normal ☐ Abnormal

Last Pap smear: _____ (date) ☐ Normal ☐ Abnormal

REVIEW OF SYSTEMS: Please check each box that applies to you.

Gastrointestinal /Genitourinary
- ☐ Loss of appetite
- ☐ Stomach ulcer
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody stool
- ☐ Nausea
- ☐ GI pain
- ☐ Difficulty urinating
- ☐ Incontinent (bowel / bladder)

Breast
- ☐ Nipple discharge
- ☐ Breast pain
- ☐ Breast lump(s)
- ☐ Uneven breasts

Cardiopulmonary
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Palpitations

Cutaneous
- ☐ Cold Sores
- ☐ Acne / Cysts
- ☐ Accutane used

Orthopedic
- ☐ Broken bones
- ☐ Arthritis / Joint pain

Psychological and Dependency
- ☐ Anxiety or Depression
- ☐ Sexual abuse
- ☐ Alcoholism
- ☐ Substance abuse

Neurologic
- ☐ Seizure
- ☐ Migraine headaches
- ☐ Weakness
- ☐ Vision changes
- ☐ Auditory changes

Other
- ☐ Easy bruising or bleeding
- ☐ Infections

COMMENTS: Please note any other comments you have that will help us provide you with the best possible care.

_____

_____

_____

_____