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**PERSONAL HEALTH QUESTIONNAIRE**

**MEDICAL EVALUATION:** How is your general health? \_\_\_\_\_

Are you presently being treated for any medical conditions? \_\_\_\_\_

When was your last physical examination? \_\_\_\_\_ Primary Physician? \_\_\_\_\_

**EYE**

Visual Loss (one or both eyes)	Yes	No
"Dry" eyes	Yes	No
Itching or irritation on eyes	Yes	No
Blurred or double vision	Yes	No
Crossed or lazy eyes	Yes	No
Cornea problems	Yes	No
Thyroid eye disease	Yes	No
Wear glasses or contacts	Yes	No
Previous eye or eyelid surgery	Yes	No
If yes, what type _____		

**NOSE**

Difficulty breathing through nose	Yes	No
Previous injury to nose	Yes	No
Nasal allergies	Yes	No
Nose bleeds	Yes	No
Sinus conditions	Yes	No
Previous nasal or sinus surgery	Yes	No
If yes, what type _____		

**FACE**

Previous aesthetic plastic surgery	Yes	No
If yes, what type _____		
Irradiation to face or neck	Yes	No
Facial paralysis or weakness	Yes	No
Facial skin problems	Yes	No
Other skin problems	Yes	No
If yes, what type _____		

**ALLERGIES**

Any drug allergies	Yes	No
(Including local anesthetics and codeine)		
If yes, please list drug and reaction type		
_____		
_____		
_____		

**CARDIOVASCULAR**

Coronary or heart attack	Yes	No
Congenital heart disease	Yes	No
Heart Murmur	Yes	No
Palpitations or irregular heart beat	Yes	No
Hypertension	Yes	No
Stroke	Yes	No

**CHEST**

Shortness of breath	Yes	No
Chronic lung disease	Yes	No
Cough	Yes	No
Asthma	Yes	No

**BREAST**

Pain or discomfort	Yes	No
Do you have cysts or lumps in your breast	Yes	No
Have you had breast biopsies	Yes	No
Has anybody in your family had breast cancer. If yes, who _____	Yes	No
Have you had a mammogram done	Yes	No
If yes, when _____		

**PSYCHIATRIC**

Have you received psychiatric treatment	Yes	No
If yes, were you hospitalized	Yes	No
Any recent crisis in your life	Yes	No

**OTHER**

Liver disorder (hepatitis, cirrhosis)	Yes	No
Kidney or bladder disorders or chronic Infections	Yes	No
Spinal or back disorders	Yes	No
Previous blood clots or thrombophlebitis	Yes	No
Any bleeding disorders in self or family	Yes	No
Blood Transfusions	Yes	No
Diabetes	Yes	No
Autoimmune disease	Yes	No
(Including lupus, rheumatoid arthritis, etc)		
Any unusual scarring or keloids	Yes	No
If applicable, are you pregnant	Yes	No
Stomach or digestive disorder	Yes	No
Thyroid problem	Yes	No

# HEALTH QUESTIONNAIRE CONTINUED

## MEDICATIONS

List any medications you are presently taking and the dosage (within the last month)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## SOCIAL

Do you smoke Yes No  
If so, how many packs per day \_\_\_\_\_

Alcohol consumption Yes No  
Drinks per day \_\_\_\_\_

Recreational drug use Yes No  
If so, which drugs \_\_\_\_\_

## CHILDHOOD MEDICAL HISTORY

Are you taking aspirin or medication containing aspirin Yes No  
Have you taken any steroid (cortisone) over the past year Yes No  
Are you taking any Vitamin E Yes No

Had all known "baby shots" Yes No  
Had polio immunization Yes No  
Had rheumatic fever Yes No

**Your height** \_\_\_\_\_  
**Your weight** \_\_\_\_\_

## FAMILY HISTORY

Any family history of medical problems or illness?

Mother \_\_\_\_\_ Sister \_\_\_\_\_  
Father \_\_\_\_\_ Brother \_\_\_\_\_

## SURGERY (Operations)

Type	Date	Complications or difficulties
1. _____		
2. _____		
3. _____		
4. _____		

## ADMISSIONS TO HOSPITALS

Reason	Date	Complications or difficulties
1. _____		
2. _____		
3. _____		

## WHAT PLASTIC SURGERY CONCERNS WOULD YOU LIKE TO DISCUSS ?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date