

# Great Lakes Plastic, Reconstructive and Hand Surgery, P.C.

## History and Physical

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Disease History:** Do you have or have had any of the following:

### A. Lungs

- Bronchitis
- Emphysema
- Asthma
- Tuberculosis (TB)
- Sinusitis
- Cold/Respiratory Inf.
- Chronic cough
- Phlegm while coughing
- None
- Other: \_\_\_\_\_

### B. Heart

- High blood pressure
- Heart disease
- Heart attack
- Heart murmur
- Chest pain
- Shortness of breath
- Chest discomfort/exercise
- Heart thumping/racing
- Mitral valve prolapse
- Pacemaker
- None
- Other: \_\_\_\_\_

### C. Vascular

- Circulatory problems
- Anemia
- Sickle cell
- Bleeding tendencies
- Nose bleeds
- Calf pain
- Ankle swelling
- Blood clot
- Blood transfusion
- (Date: \_\_\_\_\_)
- None
- Other: \_\_\_\_\_

### D. Systemic

- Diabetes (sugar)
- Glandular trouble
- Thyroid/Hormone
- Night sweats
- Unusual lumps
- Nipple discharge
- Stomach/bowel problems
- Hepatitis
- Yellow jaundice
- Ulcers/hiatal hernia
- Medication port
- Alcoholism
- AIDS
- None
- Other: \_\_\_\_\_

### E. Kidney/Bladder

- Urinate frequently
- Urinary pain/itching
- Urinary infections
- Leakage
- Kidney stones
- Bloody urine
- Gynecological disease
- None
- Other: \_\_\_\_\_

### F. Musculo/Skeletal

- Muscle weakness
- Arthritis
- Back/neck injury
- Broken bones
- None
- Other: \_\_\_\_\_

### G. Nervous System

- Headaches
- Nervousness
- Fainting/dizziness
- Epilepsy/seizures
- Head injury
- Nerve injury
- Stroke
- Psychological problems
- None
- Other: \_\_\_\_\_

### H. Teeth/Mouth

- Mouth sores
- Loose teeth
- Dentures  
(upper, lower, partial)
- None
- Other: \_\_\_\_\_

### I. Eye/Ear/Nose

- Eye pain
- Double vision
- Glaucoma/cataract
- Hearing loss
- Ringing ears
- None
- Other: \_\_\_\_\_

### J. Skin

- Acne
- Psoriasis
- Dermatitis
- Bruise easily
- Skin disease
- None
- Other: \_\_\_\_\_

**Current Medications:** (Drug, dosage, frequency and length of time you have been taking it.)

\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** Do you have any sensitivities? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
To medications (please list): \_\_\_\_\_

\_\_\_\_\_  
To X-ray dye (explain): \_\_\_\_\_

\_\_\_\_\_  
Other: \_\_\_\_\_

**Previous Surgery:** Have you had any previous surgery? Yes \_\_\_\_\_ No \_\_\_\_\_

Year: \_\_\_\_\_ Reason: \_\_\_\_\_

Year: \_\_\_\_\_ Reason: \_\_\_\_\_

Year: \_\_\_\_\_ Reason: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

**Anesthesia:** Have you had difficulty with anesthesia before? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

**Personal History:**

Are you currently pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had cancer? Yes \_\_\_\_\_ No \_\_\_\_\_

What is your average daily consumption of:

Coffee/tea/pop/caffeine: \_\_\_\_\_

Tobacco: \_\_\_\_\_ x how many years? \_\_\_\_\_

Alcohol: \_\_\_\_\_

Mind altering/recreational drugs: \_\_\_\_\_

**Family History:**

Ages of death of family: Mother \_\_\_\_\_ Father \_\_\_\_\_ Siblings \_\_\_\_\_

Please list any disease/health condition that runs in your family:

\_\_\_\_\_  
\_\_\_\_\_

**Current History:**

Briefly describe your present condition:

\_\_\_\_\_  
\_\_\_\_\_

When was the last time you saw your primary care physician? \_\_\_\_\_

Do you have any physical restrictions/limitations? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Are you right or left hand dominant? Right \_\_\_\_\_ Left \_\_\_\_\_

Date of injury? \_\_\_\_\_

Employer: \_\_\_\_\_

Describe what type of work you do: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**What may be important that has not been asked?**

\_\_\_\_\_  
\_\_\_\_\_

Answers to the above represent a true/complete History to the best of my knowledge:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have reviewed this information and found it to be complete and accurate:

Initials: \_\_\_\_\_ Date: \_\_\_\_\_