Barnes-Jewish Hospital

BJC HealthCare

Washington University in St. Louis Physicians

General Health Questionnaire for Division of Plastic Surgery

Please answer all questions on the following pages by placing a check mark in the appropriate YES or NO column. If necessary, write additional information in the Comment section.

Patient Name: _____ Date: _____

Reason for visit: _____

What other physicians would you like us to notify regarding your care today?

Primary Care Physician	**Referring Physician or Other (please circle which)**
Name:	Name:
Address:	Address:
Phone:	Phone:
Current Medications (prescribed and over the counter)	**Allergies to Medications**
(ok to attach list)	
	Do you have a LATEX allergy (circle one)? yes no

DO YOU HAVE A HISTORY OF	YES	NO	DO YOU HAVE A HISTORY OF	YES	NO
Heart or Circulation Diseases			**Urinary/Kidney/Bladder Diseases**		
Heart murmur / valve disease			Renal failure and/or dialysis		
Heart attack: Month/Year _____			Kidney stones		
Irregular heart beat/palpitations			Frequent urinary infections		
High blood pressure/hypertension			Urinary problems		
Low blood pressure			**Head or Neurologic Diseases**		
Stroke history			Seizure or black outs		
Anemia/sickle cell anemia			Frequent headaches		
Angina/chest pain			Weakness in an arm or leg		
Bleeding problems			**Endocrine/Immunologic Diseases**		
Deep venous thrombosis/pulmonary embolism (blood clot in leg/lungs)			Diabetes (*circle all that apply*): controlled by diet / insulin /pills		
Swollen ankles/legs/poor circulation			Low blood sugar/ hypoglycemia		
Cardiac Cath, EKG, Stress Test			Thyroid problems		
Lung or Breathing Diseases			Autoimmune / collagen vascular disease		
Asthma – Last attack_____			Do you take steroids (prednisone/other)		
Bronchitis			**Digestive/Stomach/Liver Diseases**		
Shortness of breath: (*if yes circle when) resting / walking / climbing stairs*			Hiatal hernia / acid reflux / ulcers (*circle any that apply*)		
Chronic lung disease			Jaundice (yellow skin)		
Pneumonia: were you hospitalized/when?			Diarrhea/Constipation		
Sleep apnea: Do you use CPAP?			Difficulty swallowing		
Frequent / productive cough			**Musculoskeletal/Joint/Skin Diseases**		
Abnormal chest x-ray			Difficulty walking		
Infectious Diseases			Back pain/problems		
Hepatitis B or C			Joint replacement		
HIV / AIDS			Arthritis		
TB / positive PPD			Rashes / itching / sores (*circle*)		
Any other recent infections/cold?			Other skin lesions?		

DO YOU HAVE A HISTORY OF	YES	NO
Mental Health Issues *(circle)*		
Depression / anxiety / panic disorder		
Anorexia / bulimia / eating disorder		
Violent behavior history		
For Women Only		
Any history of reproductive disease/Ca?		
Could you possibly be pregnant?		
Date of last menstrual period?		
Number of pregnancies / live births:		
Age at menopause:		
Social History		
Married ____ Single ____ Widowed ____ Divorced ____ Significant Partner____		
Occupation:		
Children (ages):		
Tobacco use? (*circle yes or no*)	**YES**	**NO**
Packs per day____ for _____ years Date Quit: _____		
Any other tobacco products? (pipe, cigar, chewing tobacco, etc.) (*circle yes or no*)	**YES**	**NO**
Alcohol use? How much a day?	**YES**	**NO**
Street drug use? *(circle yes or no)* (cocaine, PCP, methamphetamines, any IV drugs, marijuana)	**YES**	**NO**
Family History (please indicate relationship and whether alive/deceased), specifically address:		
Any problems with anesthesia?		
Any : cancer, cardiac disease, diabetes, seizures		
Other:		

DO YOU HAVE A HISTORY OF	YES	NO
ENT/OPHTHO		
Difficulty hearing/speaking (*circle*)		
Dentures / bridge / plate (*circle*)		
Chipped or loose teeth (*circle*)		
Glasses/contact lenses (*circle*)		
Cataracts / glaucoma (*circle*)		
Surgery History		
Any problems with anesthesia?		
Blood products or transfusion? If yes, any reaction?		

Past Medical/Surgical History:
List previous surgeries, any other hospitalizations/major illnesses or anything else we may have missed:

COMMENTS: _____

_____

_____

_____

_____

What is your HEIGHT :_____
WEIGHT :_____

Completed by *(circle one)*: Patient Other Signature_____
Reviewed by:

_____
(Physician Signature / date)