Washington University Physicians
Washington University School of Medicine in St. Louis
Department of Surgery
Division of Plastic and Reconstructive Surgery

Date: _____
Patient Name:_____ Date of Birth: _____
Address: _____ City: _____ State: _____
Phone Number (DAY): (____) _____-_____ Alternate Number: (_____) _____-_____
Social Security Number: _____ Marital Status: Married Widowed Single
Insurance Company Name: _____ Certificate #: _____
Primary Care Physician: _____ Phone #: _____
Emergency Contact: Name: _____ Phone #: _____
How were you referred to us? _____
What physicians would you like us to provide information regarding your visit here today with?

Physician Name – specialty	Address

Have you had a complete medical exam in the past year? ☐ No ☐ Yes, when _____
and by whom: _____

Please list all medications and dosages below:

Medication Name	Dosage	Why do you take it?

Are you allergic to any medications? ☐ No ☐ YES – PLEASE LIST
_____

Do you have any significant family history of the following diseases (parents or siblings).
Heart disease? ☐ No ☐ Yes, if so, who had it and what did they have? _____
Cancer? ☐ No ☐ Yes, if so, who had it and what did they have? _____
Problems with Anesthesia? ☐ No ☐ Unknown ☐ Yes, if so, who and what reaction? _____
Diabetes? ☐ No ☐ Yes, if so, who had it and did they take insulin? _____

Have you ever had surgery? ☐ No ☐ Yes – if so, please complete next table:

Name of Surgery	Year	Hospital

If you've had surgery, have you ever had any abnormal bleeding or scarring after surgery? ☐ No ☐ Yes, please explain: _____

If you've had surgery, did you experience any problems with the anesthesia? ☐ No ☐ Yes, please explain: _____

If you've had surgery, did you have a problem during surgery that you are aware of? ☐ No ☐ Yes, please explain: _____

Have you ever been treated for any of the following conditions or problems?

Condition	Yes or No	Explain
Arthritis, muscle or joint problems	Yes No	
Heart rhythm problem	Yes No	
Heart attack or failure	Yes No	
Heart valve replacement	Yes No	
Recurrent chest pains	Yes No	
Heart murmer	Yes No	
Mitral valve prolapse	Yes No	
Rheumatic fever	Yes No	
Congenital heart disease	Yes No	
High blood pressure	Yes No	
Pace maker	Yes No	
Unusual bleeding from gums	Yes No	
Do you wear complete or partial dentures	Yes No	
Psoriasis, herpes, skin rashes	Yes No	
Glaucoma	Yes No	
Cataracts	Yes No	
History of retinal detachment or corneal ulcer	Yes No	
Do you wear glasses or contacts	Yes No	
Diabetes	Yes No	
Any ear, nose or throat problems	Yes No	
Difficulty swallowing/chronic hoarseness	Yes No	
Any history of venereal disease	Yes No	
Any difficulty with urination	Yes No	
Menstrual irregularities or bleeding	Yes No	
Anemia	Yes No	
Easy bruising	Yes No	
HIV + or AIDS	Yes No	
Hepatitis	Yes No	
Have you ever had a nervous breakdown	Yes No	
Have you ever seen a psychiatrist or psychologist	Yes No	
Epilepsy, fainting spells, seizures	Yes No	
Depression	Yes No	
Frequent headaches	Yes No	

What area (s) of your body are you dissatisfied with?

_____

_____

Which area is your top priority? What would you like it to look like? _____

_____

Questions I have for the doctor:

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

I have reviewed this questionnaire.

_____ _____

Physician's Signature Date