Wendy R. Gottlieb, M.D., P.L.C
Plastic and Reconstructive Surgery

Health History Form

Patient's Name:	**Marital Status** ___S___M___W___D	**D.O.B.:**	**Date:**

Reason for visit:

Duration of symptoms:

Previous treatment, if any:

Height:	**Weight:**	**Pregnancies:**	**Live births:**	**Children:**

Ongoing and previous medical problems (please circle) :

Diabetes **High blood pressure** **Heart disease** **Asthma** **High cholesterol**
Thyroid disease **Breast Cancer** **Skin Cancer** **HIV/AIDS** **Hepatitis**
Other Cancer_____ **Other:**_____

Surgeries (Please include date and surgeon):

Procedure:	**Date (Mo/yr):**	**Surgeon:**

Medications (Please include over the counter and herbal medications):

Medication:	**Dose/Schedule:**	**Prescribing Doctor/Reason for medication:**

Allergies:	**Reactions:**

Do you smoke? YES NO	**Have you ever? YES NO**	**If YES, how many packs per day?**

How many years did you smoke?	**If stopped, when?**
Alcohol Intake?	**Recreational Drug Use?**
Last Mammogram:	**Last Tetanus Shot:**

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Name: _____

Please check the box that corresponds to the frequency of the symptoms listed:

	Currently	Please explain
Eye problems		
Hearing problems		
Fever		
Chills		
Muscle aches		
Joint pain		
Back pain		
Endocrine/hormonal		
Headaches		
Nerve problem		
Seizures		
Stroke		
Heart murmur		
Irregular heartbeat/palpitations		
Chest pain		
Shortness of breath		
Breathing problems		
Urinary problems		
Psychiatric conditions		
Skin problems		
Gastrointestinal complaints		
Bleeding problems		
Leg swelling		
Cancer or tumor		

Family history please indicate all primary family members, aunts, uncles, and grandparents. If deceased, provide age and cause of death.

Is there anything else we should know about you?