CalvertHealth™
Medical Group

Plastic Surgery Questionnaire

Today's Date:
Name: DOB: Age: Sex: ☐ M ☐ F
Reason for today's visit:
Primary Care Provider: Referring Provider:
Do you see a cardiologist? ☐ No ☐ Yes Physician Name :

Medical History

Cardiovascular
- ☐ Hypertension
- ☐ Chest Pain
- ☐ MI/CAD
- ☐ Palpitations/Arrhythmia
- ☐ Pacemaker/AIDC
- ☐ Valvular Disease
- ☐ Coronary Stent
- ☐ Hyperlipidemia
- ☐ Diabetes, Type: Last HG1C:

Pulmonary
- ☐ Asthma
- ☐ COPD
- ☐ Cough
- ☐ Shortness of breath
- ☐ Sleep Apnea
- ☐ Wheezing
- ☐ Bronchitis
- ☐ Tuberculosis

GI Endocrine
- ☐ Hernia
- ☐ Reflux
- ☐ Hepatitis, Type:
- ☐ Liver Disease
- ☐ Thyroid Disease
- ☐ Obesity
- ☐ PVD
- ☐ Ulcers

Neuromuscular
- ☐ TIA or Stroke
- ☐ Seizures
- ☐ Cerebrovascular Disease
- ☐ Dementia
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ History of DVT, PE
- ☐ Cancer, Type:

Hematologic
- ☐ Anemia
- ☐ HIV/AIDS
- ☐ Bleeding Disorder
- ☐ Chemotherapy
- ☐ Neuromuscular Disease
- ☐ Factor V Liden
- ☐ Syncope
- ☐ Conditions not listed:

Miscellaneous
- ☐ Cataracts
- ☐ Drug Dependency
- ☐ Glaucoma
- ☐ Prostate Problems
- ☐ Anxiety
- ☐ Psychiatric Disorder
- ☐ Depression

Name of Medication	Strength of Medication	Dosing Instructions
Example: Tylenol	Example: 500Mg	Example: 1 pill three times a day

* Note: this information may be taken directly from the pharmacy label on prescription products.

ALLERGIES			
☐ No known allergies	☐ Medication Allergies	☐ Environmental/Seasonal Allergies	☐ Latex Allergy
List Allergies			

CalvertHealth™
Medical Group

Plastic Surgery Questionnaire

Family History

Mother

☐ Diabetes ☐ Lung Disease ☐ Heart Disease ☐ Cancer ☐ Other
☐ Living ☐ Deceased; If so, was it cause of death? ☐ No ☐ Yes Age of death

Father

☐ Diabetes ☐ Lung Disease ☐ Heart Disease ☐ Cancer ☐ Other
☐ Living ☐ Deceased; If so, was it cause of death? ☐ No ☐ Yes Age of death

Siblings

☐ Diabetes ☐ Lung Disease ☐ Heart Disease ☐ Cancer ☐ Other
☐ Living ☐ Deceased; If so, was it cause of death? ☐ No ☐ Yes Age of death

Grandparents

☐ Diabetes ☐ Lung Disease ☐ Heart Disease ☐ Cancer ☐ Other
☐ Living ☐ Deceased; If so, was it cause of death? ☐ No ☐ Yes Age of death

PAST SURGICAL HISTORY +

Type of Surgery (operation)	Date

SOCIAL HISTORY

Tobacco

Have you ever smoked? ☐Yes ☐ No
Are you still smoking? ☐Yes ☐No
If no: How many years ago did you quit?

If yes, what do you (did you) smoke?
If yes: How many years have you smoked?
Do you Vape? ☐Yes ☐ No

Alcohol

 Do you drink alcohol, including beer, wine or hard liquor? ☐Yes ☐No
If yes: ☐Daily ☐ Almost Daily (4-6 times per week) ☐1 – 3 times per week ☐ Less than one time per week

Illicit Drugs

Do you use any drugs or prescription medications not prescribed to you? ☐Yes ☐No
(Including marijuana, cocaine, amphetamines, pain or anxiety medications, etc.)
If yes, please specify type of drug and frequency of use:

Women:

Last Mammogram Date: ☐Normal ☐Abnormal ☐Unknown
Perform regular breast exam? ☐Yes ☐No