HISTORY & PHYSICAL

Plano Center for Surgical Arts

Please print and complete all blanks

Patient Name: _____ Today's Date: _____ Date of Birth: _____

What brings you in today? _____

Are you here related to a work injury? _____ Occupation: _____

Age: _____ Height: _____ Weight: _____ Gender: _____

Are you currently under a physician's care? If so, please list all physicians who are currently treating you

Physician's Name:	**Specialty:**

Medical History: *Please answer the following questions*

Do you have sleep apnea, use CPAP or BiPAP?	☐ Yes ☐ No	Do you have a history of liver disease or cirrhosis?	☐ Yes ☐ No
Do you experience shortness of breath or chest pain when climbing two flights of stairs?	☐ Yes ☐ No	In the past two years, have you required prolonged treatment with steroids?	☐ Yes ☐ No
Do you have high blood pressure which requires treatment with medication?	☐ Yes ☐ No	Do you have Diabetes which requires treatment with medication or insulin?	☐ Yes ☐ No
Do you have a history of blood clots, stroke, carotid artery blockage or TIA's (mini strokes)?	☐ Yes ☐ No	Do you have a history of excessive bleeding after surgical or dental procedures?	☐ Yes ☐ No
Are you currently taking blood thinners such as Coumadin, Plavix or Aspirin?	☐ Yes ☐ No	Do you have any implanted medical devices? Device: _____ Year: _____	☐ Yes ☐ No
Do you have kidney issues (except kidney stones or recurrent infections) that require treatment by a kidney specialist?	☐ Yes ☐ No	Within the last 6 months have you taken anabolic steroids or prohormones? When?_____ What Dose? _____	☐ Yes ☐ No

Surgical History: ☐ Never had surgery

Type of Surgery/Procedure:	**Year**	Have you, or anyone in your immediate family ever had complications with anesthesia? ☐ Yes ☐ No Complication: _____

Social History:

Do you use nicotine? ☐ Yes ☐ No	Which product?	How much per day?
Do you consume alcohol? ☐ Yes ☐ No	How many drinks?	How often?
Do you use recreational drugs? ☐ Yes ☐ No	Which drug?	How often?

Allergies: *Please list all allergies to medications* ☐ No Known Allergies

Medication:	**Reaction:**	Are you allergic to latex? ☐ Yes ☐ No Reaction: _____ Are you allergic to shellfish? ☐ Yes ☐ No Reaction: _____

Current Medications: *Please list all medications you are currently taking including prescription, over the counter and supplements*

Medication/Supplement:	**Dose:**	**Frequency:**	
			☐ Not taking any medications

Which pharmacy do you use? _____ Pharmacy Phone Number _____

Patient Signature _____ Today's Da

Plano Center for Surgical Arts

HISTORY & PHYSICAL

-over-

DETAILED HEALTH QUESTIONAIRRE

Please provide detailed information so we can take the best possible care of you!

Cardiovascular					
High blood pressure	☐ Yes ☐ No	Coronary artery disease	☐ Yes ☐ No	Irregular heart beat	☐ Yes ☐ No
Low blood pressure	☐ Yes ☐ No	History of heart attack	☐ Yes ☐ No	Pacemaker/Defibrillator	☐ Yes ☐ No
Chest pain	☐ Yes ☐ No	Congestive heart failure	☐ Yes ☐ No	Abnormal EKG	☐ Yes ☐ No
Sickle cell disease	☐ Yes ☐ No	Prolonged bleeding	☐ Yes ☐ No	History of blood clots	☐ Yes ☐ No
If you answered YES to any of the above questions, please provide details: _____					
Respiratory					
Difficulty breathing	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Nasal allergies	☐ Yes ☐ No
Chronic cough	☐ Yes ☐ No	COPD/emphysema	☐ Yes ☐ No	Sleep apnea	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Nose bleeds	☐ Yes ☐ No	Nasal obstruction	☐ Yes ☐ No
Digestive					
Heartburn / Reflux	☐ Yes ☐ No	Weight loss surgery	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No
Obesity	☐ Yes ☐ No	Eating Disorder	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Urinary					
Frequent UTI	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Dialysis – When?	☐ Yes ☐ No
Endocrine					
Diabetes	☐ Yes ☐ No	Hyperthyroid	☐ Yes ☐ No	Hypothyroid	☐ Yes ☐ No
Neuro					
Epilepsy	☐ Yes ☐ No	History of seizures	☐ Yes ☐ No	Fainting /dizziness	☐ Yes ☐ No
Migraines	☐ Yes ☐ No	History of stroke	☐ Yes ☐ No	Nerve pain	☐ Yes ☐ No
If you answered YES to any of the above questions, please provide details: _____					
Sensory					
Blurry vision	☐ Yes ☐ No	Dry eyes	☐ Yes ☐ No	Previous eye surgery	☐ Yes ☐ No
Contacts / Glasses	☐ Yes ☐ No	Hearing loss	☐ Yes ☐ No	Hearing aids	☐ Yes ☐ No
Musculoskeletal					
Arthritis	☐ Yes ☐ No	Rheumatoid arthritis	☐ Yes ☐ No	Fibromyalgia	☐ Yes ☐ No
Back/neck pain	☐ Yes ☐ No	TMJ	☐ Yes ☐ No	Are you a body builder?	☐ Yes ☐ No

Are you currently taking prescription pain medication?		☐ Yes ☐ No		Which medication are you taking?			
Psychiatric							
Anxiety	☐ Yes ☐ No	Depression		☐ Yes ☐ No	Suicidal thoughts or actions	☐ Yes ☐ No	
Claustrophobia	☐ Yes ☐ No	Bipolar disorder		☐ Yes ☐ No	Body dysmorphic syndrome	☐ Yes ☐ No	
If you have a history of suicidal thoughts or actions, when did this occur?							
Cancer							
History of cancer	☐ Yes ☐ No	What type and area?					
Radiation therapy	☐ Yes ☐ No	Chemotherapy		☐ Yes ☐ No	Still on treatments?	☐ Yes ☐ No	
Abnormal mammogram	☐ Yes ☐ No	Breast pain	☐ Yes ☐ No	Family history of breast cancer		☐ Yes ☐ No	
Female Reproductive							
Could you be pregnant?	☐ Yes ☐ No	When was your last menstrual period?					
Hysterectomy	☐ Yes ☐ No	Menopause	☐ Yes ☐ No	How many years?			
Infectious Disease							
HIV	☐ Yes ☐ No	Hepatitis B	☐ Yes ☐ No	Hepatitis C	☐ Yes ☐ No	History of tuberculosis	☐ Yes ☐ No

Do you have any other health related issues other than those listed above? If YES, please explain: _____

_____

Patient Signature _____ Today's Date _____

I HAVE REVIEWED THIS H&P WITH THE PATIENT

SIGNATURE OF CLINIC INTERVIEWER/CLINIC PRE-OPERATIVE STAFF

DATE/ TIME

-over-

_____

Physician Signature _____ Date _____ Time _____