PLASTIC SURGEONS of Northern Arizona | THE HAND CENTER of Northern Arizona

HEALTH HISTORY

Name: _____ Age _____

Height _____ Weight_____ BMI (body mass index, if known)_____

Have you been vaccinated for COVID-19? ___ Yes ___ No Booster? ___ Yes ___ No

SOCIAL HISTORY:
Are you currently using tobacco? ___Yes ___No If yes, what year did you start? _____
Packs per day _____ Smokeless tobacco? ____Yes ____No

Have you used tobacco in the past? ___Yes ____No **If yes,** what **year** did you start and what **year** did you quit?
Year started _____ Year quit _____

Do you vape? ___Yes ___No **If yes,** is there nicotine in the vape? ___ Yes ___ No
Are you currently using nicotine from any other source? ___ Yes ____ No

Alcohol use: ___Never ____Rare ____Moderate ____ Daily
Recreational drug use: ___Yes ____No If yes, what drug(s)? _____
Are you approved for Medical Marijuana use? ____Yes ___No

Chronic opioid user? ___Yes ___No If yes, do you have a pain contract? ___Yes ___No

Do you exercise routinely? ___Yes ___No
Can you climb a flight of stairs without getting short of breath? ___Yes ___No

MEDICATIONS/ALLERGIES:
Have you ever had an allergic reaction to any medications? ___Yes ___No If yes, what medication?
_____ and what reaction?_____

Have you ever had an allergic reaction to X-ray or Contrast Dye? ____Yes ___No If yes, describe: _____
Have you ever had a latex allergy? ___Yes ___No Have you ever had a tape/adhesive allergy? ___Yes ___No

Prescription Medications Dosage (mg) Frequency (once, twice per day, etc.)
_____ _____ _____
_____ _____ _____
_____ _____ _____
Non-Prescription Medications (including over-the-counter drugs, supplements, herbs, vitamins, aspirin, etc)
_____
Preferred Pharmacy you use:
_____
Have you taken cortisone/steroid drugs? ___Yes ___No
Have you ever had blood products transfused? ___Yes ___No If yes, when? _____ where?_____

PLEASE COMPLETE PAGE 2 OF HISTORY

PAST MEDICAL HISTORY: Please check illnesses / conditions that you have had or currently have:

Asthma	Bleeding tendencies	Blood clots	Bronchitis	Cancer (type)	Diabetes	Elevated cholesterol
Heart disease	Hepatitis	High blood pressure	HIV	Sleep apnea	Glaucoma	Kidney disorder/stones
Jaundice	Obesity	Pneumonia	STD	Nervous disorder	Stroke/TIA	Tuberculosis
Reflux/PUD	Rheumatic fever	Cold sores/ fever blisters	Hives/rash	Eczema	Frequent urination	Burning/painful urination
Blood in urine	Skin diseases	Thyroid disorder	Dizziness/loss of consciousness	Easy bruising	Heavy bleeding after surgery	Slow to heal after cuts
Multiple sclerosis	Fragile skin / burn easily	Other				

Are you currently experiencing any cold or flu-like symptoms? _____ yes ____ no

SURGICAL HISTORY: Previous operations or hospitalizations.
Please list procedure, year, and describe anesthesia complications (if any):

_____
_____
_____
_____

Have you had any serious injuries, broken bones, etc? Yes___ No___ If yes, please list

_____
_____

FAMILY HISTORY:

Please check illnesses that have occurred in any of your **BLOOD RELATIVES,** and list which relative(s):

(M = mother. F = father. B = brother. S = sister. PGM = paternal grandmother. MGM = maternal grandmother PGF = paternal grandfather. MGF = maternal grandfather. A = aunt. U = uncle. C = cousin. CH = child. GC = grandchild)

Bleeding tendencies _____ Diabetes _____ High Blood Pressure _____
Nervous disorder _____ Cancer (type)_____
Heart disease _____ Kidney disease _____ Stroke _____
Other illness: _____

Woman Only:
Are you pregnant? ___Yes ___No
During pregnancy do you have hypopigmentation or masking? ___Yes ___No
Do you have regular periods? ___Yes ___No
Are you going through menopause? ___Yes ___No
Date of last menstrual period: _____
Date of most recent mammogram: _____

Patient or responsible party signature _____ Date: _____