

Wendy R. Gottlieb, M.D., P.L.C

Plastic and Reconstructive Surgery

Health History

| | | |
|---|---------------------------|--------------------------------|
| Patients Name: | | D.O.B. |
| Reason for visit: | | |
| Duration of symptoms: | | |
| Previous treatment, if any: | | |
| Hobbies: | | Marital status: |
| Ongoing and previous medical problems (please circle) : Diabetes High blood pressure Heart disease asthma other: | | |
| Surgeries, please include date and surgeon: | | |
| Medication, including dose and schedule, please include over the counter and herbal medications: | | |
| Allergies: | | |
| Last tetanus shot? | Height: | Weight: |
| Do you smoke? Y N | Have you ever? Y N | How many packs per day? |
| Alcohol intake: | | Recreational Drug use: |

Currently Past Never Please explain

| | Currently | Past | Never | Please explain |
|--|-----------|------|-------|----------------|
| Eye, Hearing problems | | | | |
| Fever, chills | | | | |
| Muscle aches, joint pain | | | | |
| Back pain | | | | |
| Endocrine/hormonal | | | | |
| Headaches, nerve problem | | | | |
| Seizures, stroke | | | | |
| Heart murmur, irregular heart beat, palpitations | | | | |
| Chest pain | | | | |
| Shortness of breath, breathing problems | | | | |
| Urinary problems | | | | |
| Psychiatric conditions | | | | |
| Skin problems | | | | |
| Gastrointestinal complaints | | | | |
| Bleeding problems | | | | |
| Leg swelling | | | | |
| Cancer or tumor | | | | |
| HIV | | | | |
| Hepatitis | | | | |

Family history please indicate all primary family members, aunts and uncles and grandparents, if deceased , age and cause of death:

Is there anything else you feel we should know about you?