
Franciscan Plastic & Reconstructive Surgery Associates

A part of the Franciscan Medical Group

Medical History Form Todd M. Willcox, MD

Patient Name: _____ **Primary Language:** _____

D.O.B.: _____ **Stated Height:** _____ **Stated Weight:** _____ **Contact Person:** _____

Referring Physician: _____ **Primary Care Physician:** _____

Other Physicians you see (example: Heart, Lung, Endocrine specialist):

_____ M.D. Type: _____

_____ M.D. Type: _____

Reason for visit: _____

Have you ever seen another surgeon for the same problem or concern? Yes No

Medical History: (Please circle yes or no.)

Neurological:

Migraine/ Headache	Yes	No
Fainting	Yes	No
Stroke / TIA / Paralysis	Yes	No
Seizures	Yes	No
Glaucoma	Yes	No

Brain Aneurysm / Head Injury	Yes	No
Macular Degeneration	Yes	No
Retinal Detachment	Yes	No
Blindness	Yes	No
Other: _____	Yes	No

Pulmonary:

Asthma	Yes	No
Aspiration	Yes	No
Sleep Apnea	Yes	No
Pneumonia / Bronchitis	Yes	No
Emphysema / COPD	Yes	No

Deep Vein Thrombosis	Yes	No
Pulmonary Embolism	Yes	No
Pulmonary Hypertension	Yes	No
Lung Cancer / Tuberculosis (TB)	Yes	No
Other: _____	Yes	No

Cardiac:

High Blood Pressure	Yes	No
Elevated Cholesterol	Yes	No
Angina/Chest pain	Yes	No
Heart Attack	Yes	No
Irregular Heart Beat	Yes	No
Atrial Fibrillation	Yes	No

Congestive Heart Failure	Yes	No
Heart Murmur / Valve Disease	Yes	No
Pacemaker / Defibrillator	Yes	No
Rheumatic Fever / Heart Infection	Yes	No
Heart Surgery / Angioplasty	Yes	No
Coronary Artery Disease	Yes	No
Other: _____	Yes	No

Gastrointestinal:

Motion Sickness	Yes	No
Diarrhea	Yes	No
Gallstones	Yes	No
Reflux / Heartburn/ Hiatal Hernia	Yes	No

Peptic Ulcers	Yes	No
Liver Disease / Cirrhosis / Jaundice	Yes	No
Irritable Bowel Syndrome	Yes	No
Other: _____	Yes	No

Franciscan Plastic & Reconstructive Surgery Associates

A part of the Franciscan Medical Group

Gyn/Breast:

Breast Cancer/ Mastectomy	Yes	No
Breast Disease	Yes	No
Endometriosis	Yes	No

Age of first period _____
Number of pregnancies _____
Last Mammogram _____

Uterine Cancer	Yes	No
Prolapse	Yes	No
Other: _____	Yes	No

Date of last period _____
Number of births _____
 Reported as normal by patient

Age of menopause _____
Breast Feeding _____
 Report interpreted as normal

Musculoskeletal:

Artificial joint / prosthesis	Yes	No
Multiple Sclerosis	Yes	No

Skin:

Cancer	Yes	No
Psoriasis	Yes	No

Psychiatric:

Depression / Anxiety	Yes	No
ADHD / Bi-Polar	Yes	No
Eating Disorder	Yes	No

Endocrine:

Diabetes	Yes	No
(if yes, insulin dependent?)	Yes	No

Renal/Genitourinary:

Kidney Stones	Yes	No
Kidney Disease	Yes	No
Kidney Failure	Yes	No

Vascular:

Aneurysm	Yes	No
Peripheral Vascular Disease/ poor circulation	Yes	No

Rheumatology:

Rheumatoid Arthritis	Yes	No
Osteoarthritis	Yes	No
Lupus / Scleroderma	Yes	No

Hematology / Infectious Disease:

Anemia	Yes	No
Bleeding Tendencies	Yes	No
Hemophilia	Yes	No
Sickle Cell	Yes	No
Leukemia / Lymphoma	Yes	No

Cancer/ Malignancy:

Location: _____
Chemotherapy Yes NO

Osteoporosis	Yes	No
Other: _____	Yes	No

Eczema	Yes	No
Other: _____	Yes	No

Schizophrenia	Yes	No
Dementia	Yes	No
Other: _____	Yes	No

Thyroid Disease	Yes	No
Hypoglycemia	Yes	No
Other: _____	Yes	No

Prostate Disease	Yes	No
Frequent Urinary Tract Infections	Yes	No
Other: _____	Yes	No

Vasculitis	Yes	No
Varicose Veins	Yes	No
Other: _____	Yes	No

Raynaud's Disease	Yes	No
Fibromyalgia	Yes	No
Other: _____	Yes	No

Sexually Transmitted Disease	Yes	No
Hepatitis	Yes	No
HIV / AIDS	Yes	No
Blood Transfusions	Yes	No
Other: _____	Yes	No

Radiation Yes NO
Date finished treatment: _____

Franciscan Plastic & Reconstructive Surgery Associates

A part of the Franciscan Medical Group

Review of Systems: (Please circle yes or no.)

General:

Changes in weight	Yes	No
Progressive/Prolonged Fatigue	Yes	No

Pulmonary:

Cough	Yes	No
Shortness of breath	Yes	No
Wheeze	Yes	No
Snoring	Yes	No

Cardiac:

Do you ever wake up short of breath	Yes	No
Leg/ Ankle swelling	Yes	No
Do you sleep okay	Yes	No
Palpitations / Heart flutters	Yes	No
Abnormal sensation with exertion/ (in chest, arms, neck, back)	Yes	No

Infectious Disease:

Fever	Yes	No
Night Sweats	Yes	No
Recent Infection	Yes	No

Gynecologic/Urologic:

Incontinence	Yes	No
Difficulty / Painful urination	Yes	No
Blood in urine	Yes	No

Psychiatric:

Suicidal thoughts	Yes	No
Hallucinations	Yes	No
Memory loss	Yes	No
Felling depressed/anxious	Yes	No

Blood/Lymph:

Easy bruising	Yes	No
Frequent nose bleeds	Yes	No
Swollen glands	Yes	No

Head and Neck:

Decrease in hearing	Yes	No
Ringing in the ears	Yes	No
New Headaches	Yes	No
Sinus Problems	Yes	No
Sore throat	Yes	No
Changes in voice	Yes	No
Dry mouth	Yes	No

Eyes:

Blurred vision	Yes	No
Eye pain	Yes	No
Redness	Yes	No
Watering	Yes	No
Light sensitive	Yes	No
Dry feeling	Yes	No

Gastrointestinal:

Frequent Nausea / Vomiting	Yes	No
Abdominal pain	Yes	No

Skin:

Changing moles	Yes	No
New rash	Yes	No
Tendency to form Keloid scars	Yes	No

Neurological:

Dizziness	Yes	No
Difficulty walking	Yes	No
Sensory changes	Yes	No

Musculoskeletal:

Weakness / Numbness	Yes	No
Neck / Back Pain	Yes	No
TMJ / Jaw Pain	Yes	No

Past Surgical History: (Please list name of procedure and date.)

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Franciscan Plastic & Reconstructive Surgery Associates

A part of the Franciscan Medical Group

Medications: (Please list all current medications and dosages.)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

Drug Allergies: YES / NO **List:** _____
Reactions: _____

Social History:

- 1. Occupation: _____
- 2. Married / Single / Divorced (circle one)
- 3. Have you ever used tobacco?: Yes No
 If yes, # of packs per day?: _____ for # of years?: _____
 If you quit using tobacco, when?: _____
- 4. Do you drink alcohol?: Yes No
 How much?: _____ How often?: _____
- 5. Do you use recreational drugs?: Yes No
 Type: _____

Family History: Please list any family medical history/problems.

	Age	Diseases	Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____

Breast Reduction Patients: (If you are here for breast reduction, please fill out the following.)

Macromastia Symptoms:

____ year old female with bilateral large heavy pendulous breast and associated symptoms of:
 neck pain back pain shoulder grooving rash under breasts for _____ years duration.

Current bra size: _____ Preferred bra size: _____

Attempts to relieve symptoms:

- Medications: aspirin Tylenol NSAID other:
Relief of Sx: none limited temporary
 Nonpharm: PT massage therapy Chiropractor
Relief of Sx: none limited temporary

Associated complaints:

- Exercise limitation from breast: mild moderate severe
 Skin changes: moisture rash redness ulcers color changes

Modifying History:

- Weight loss in last year? no yes: _____ lbs
 Associated change in breast size? no yes cup size change: _____
 Associated change in symptoms? no yes: limited/ moderate

Franciscan Plastic & Reconstructive Surgery Associates

A part of the Franciscan Medical Group

Pre-surgical / Anesthesia: (Please circle yes or no.)

Do you use aspirin or NSAIDs (Motrin, Aleve, etc)

Containing medications? Yes No

Do you use Blood thinners (Coumadin/Warfarin, Heparin, Lovenox)?

Medication name: _____

Have you used diet pills in the last two weeks?

Yes No

Medication name: _____

Have you taken steroids within the last year?

Yes No

Medication name: _____ How long?: _____

Have you ever taken Accutane? Yes No

If yes, when was you last dose?: _____

Have you or your immediate family had any reactions, Problems or complications associated with anesthesia?

Yes No

Describe: _____

Do you or your family have malignant hyperthermia?

Yes No

Describe: _____

Do you exercise? Yes No

How often?: _____ How long?: _____

Type: _____

Is your level of activity related to health limitations?

Yes No

Describe: _____

Do you wear contact lenses? Yes No

Do you have caps, bridges dentures or loose teeth?

Yes No

Describe: _____

Have you had blood drawn in the past month?

Yes No

If yes, which lab?: _____

Have you had an EKG done in the last year?

Yes No

If yes, at what location?: _____

Have you had a chest x-ray done within the last year?

Yes No

If yes, at what location?: _____

Have you ever had a mammogram?

Yes No

If yes, date of last: _____

Have you had a recent medical evaluation by your Internist, Cardiologist, or Family Practitioner?

Yes No

If yes, Doctor's name: _____

Do you have an advanced directive or living will?

Yes No

(If yes, please bring a copy with you on the day of surgery.)

ACKNOWLEDGEMENT:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Franciscan Plastic & Reconstructive Surgery Associates of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Patient Signature: _____

Date: _____

Doctor's Signature: _____

Date: _____

Reviewed and Updated:

Patient Signature: _____

Date: _____

Please note changes: