UF UNIVERSITY of FLORIDA | UFHealth PHYSICIANS

UF Health Plastic Surgery and Aesthetics Center – Springhill
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New Patient Questionnaire

Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell: _____ E-mail: _____

Where did you first hear about us?

☐ Radio ad ☐ Magazine ad ☐ Website search ☐ Post card

☐ Brochure ☐ Media article ☐ Event/seminar ☐ Social media

☐ Friend/Family member ☐ Referring physician ☐ Other: _____

Present Illness:

Why are you seeing the Doctor today: _____

_____

_____

How long have you had these symptoms: _____

_____

_____

Name of Doctor that referred you today: _____

_____

City: _____

Name of Primary Care MD: _____

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Medical History Questionnaire:

Name: _____ Age: _____

Reason for Visit: _____

Allergies and Sensitivities (please circle):

Penicillin	Aspirin	Sulfa
Other Antibiotics	Adhesive Tape	
Xylocaine/Novocaine	Shellfish	
Codeine	Eggs	

Other (list): _____ No known drug allergy ☐

Medications (circle group you are currently taking and list med):

Cortisone or Steroids: _____

Sedative, Sleeping Pills, Tranquilizers, Anti-anxiety: _____

Anti-depressant Medication: _____

Blood Pressure Medication: _____

Medication for your heart: _____

Diabetic Medication: _____

Thyroid Medication: _____

Aspirin, Coumadin, Heparin: _____

Birth Control Pills/Hormone Replacement Therapy: _____

Other: _____

Social History (please circle):

Tobacco or Cigarettes	None	Socially	1 pack/day or less	2 packs/day	Quit	If quit, what year: _____
Alcohol	None	Socially	Daily	More		
Drugs	None	Marijuana	Cocaine	Other		

Surgical History:

Type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____

Did you experience any problems or complications during or following your surgery?

No ☐ Yes ☐ If yes, please explain: _____

Past Medical History (please list any hospitalizations below):

Purpose: _____ Date: _____

Purpose: _____ Date: _____

Purpose: _____ Date: _____

If female, have you ever had a mammogram? Yes ☐ No ☐

If yes, please state most recent date and result: _____

Is there a family history of breast cancer in your family? Yes ☐ No ☐

If yes, what is their relationship to you? _____

History of clotting legs, lungs, gums? _____

Family history of clots/bleeding disorders? _____

Is there any other history not noted above which the doctor should be aware of? Yes ☐ No ☐

If yes, please explain: _____

Illness and Medical Problems:

Constitutional:	Yes	No
Fevers	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Fatigue	☐	☐
Malaise	☐	☐
Weight Loss	☐	☐

Eyes:	Yes	No
Contacts/Glasses	☐	☐
Cataracts	☐	☐
Glaucoma	☐	☐
Irritation/Redness	☐	☐
Color Blindness	☐	☐
Double Vision	☐	☐
Dry eyes	☐	☐
Tearing	☐	☐

Ears, nose, mouth, throat:	Yes	No
Hearing loss	☐	☐
Ringing in ears	☐	☐
Earaches	☐	☐
Nasal Congestion	☐	☐
Nose Bleeds	☐	☐
Snoring	☐	☐
Sore Throat	☐	☐
Hoarseness	☐	☐

Respiratory:	Yes	No
Cough	☐	☐
Sputum	☐	☐
Pneumonia	☐	☐
Wheezing	☐	☐
Shortness of breath	☐	☐

Cardiovascular:	Yes	No
Chest pain	☐	☐
Palpitations	☐	☐
Irregular heartbeat	☐	☐
Pass out or faint	☐	☐
Swelling in ankles/feet	☐	☐
Bruise easily	☐	☐

Gastrointestinal:	Yes	No
Trouble swallowing	☐	☐
Reflux	☐	☐
Nausea/Vomiting	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Blood in stool	☐	☐
Abdominal pain	☐	☐

Genitourinary:	Yes	No
Pain with urination	☐	☐
Urinary incontinence	☐	☐
Blood in urine	☐	☐

Skin:	Yes	No
Rash	☐	☐
Dryness	☐	☐
Itching	☐	☐
Skin color or change	☐	☐

Breast:	Yes	No
Breast pain or tenderness	☐	☐
Nipple discharge	☐	☐
Breast lump	☐	☐

Musculoskeletal:	Yes	No
Muscle pain	☐	☐
Joint pain/stiff joints	☐	☐
Neck pain	☐	☐
Back pain	☐	☐
Muscle weakness	☐	☐

Neurological:	Yes	No
Headaches	☐	☐
Dizziness	☐	☐
Vertigo	☐	☐
Seizures	☐	☐
Memory problems	☐	☐
Tremor	☐	☐
Weakness or numbness	☐	☐

Behavioral/Psych:	Yes	No
ADHD	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Mood disorder	☐	☐
Sleep disturbances	☐	☐

Endocrine:	Yes	No
Diabetes	☐	☐
Poor wound healing	☐	☐
Excessive thirst	☐	☐
Excessive urination	☐	☐

Other:	Yes	No
HIV	☐	☐
Hepatitis A	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐

Women Only:

	Yes	No
Heavy menstrual bleeding	☐	☐
Tender Breasts	☐	☐
Lump or recent change in size	☐	☐
Menstrual problems	☐	☐
Birth Control Pills	☐	☐
Number of Pregnancies _____		
Number of Live Births _____		
Bra Size _____		

	Yes	No
Discharge from Nipples	☐	☐
Fibrocystic Disease	☐	☐
Previous Mammogram (Year: _____)	☐	☐
Were your children breast fed?	☐	☐
Do you have breast implants?	☐	☐
Other implants?	☐	☐
Multiple Miscarriages	☐	☐

Family History:

	Yes	No
Tuberculosis	☐	☐
Asthma	☐	☐
Glaucoma	☐	☐
Cancer	☐	☐
Relation: _____		
Type of Cancer: _____		
Relation: _____		
Type of Cancer: _____		
Other: _____	☐	☐

	Yes	No
Diabetes	☐	☐
Rheumatoid Arthritis	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Blood Disorders (i.e. Sickle Cell anemia, etc.)	☐	☐
Bleeding Tendency	☐	☐

Hand/Upper Extremity Patients Only:

Right-handed _____ Left-handed _____ Is this work related? _____

Date of injury: _____ Place of injury: _____

Please describe problem: _____

_____

Side affected: _____ Left _____ Right _____ Both

List previous treatment for this problem: _____

Occupation: _____ Place of Employment: _____

This information is correct to the best of my knowledge.

_____ _____

Patient Date

_____ _____

Parent/Guardian Date