

**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: \_\_\_\_\_

**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:**

<b>Constitutional:</b>	<b>Yes</b>	<b>No</b>	<b>Genitourinary:</b>	<b>Yes</b>	<b>No</b>
Fevers .....	<input type="checkbox"/>	<input type="checkbox"/>	Pain with urination.....	<input type="checkbox"/>	<input type="checkbox"/>
Chills .....	<input type="checkbox"/>	<input type="checkbox"/>	Urinary incontinence.....	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats .....	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine .....	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>	<b>Skin:</b>	<b>Yes</b>	<b>No</b>
Malaise .....	<input type="checkbox"/>	<input type="checkbox"/>	Rash.....	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss .....	<input type="checkbox"/>	<input type="checkbox"/>	Dryness.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Eyes:</b>	<b>Yes</b>	<b>No</b>	Itching.....	<input type="checkbox"/>	<input type="checkbox"/>
Contacts/Glasses .....	<input type="checkbox"/>	<input type="checkbox"/>	Skin color or change.....	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts .....	<input type="checkbox"/>	<input type="checkbox"/>	<b>Breast:</b>	<b>Yes</b>	<b>No</b>
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Breast pain or tenderness .....	<input type="checkbox"/>	<input type="checkbox"/>
Irritation/Redness .....	<input type="checkbox"/>	<input type="checkbox"/>	Nipple discharge.....	<input type="checkbox"/>	<input type="checkbox"/>
Color Blindness.....	<input type="checkbox"/>	<input type="checkbox"/>	Breast lump .....	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision .....	<input type="checkbox"/>	<input type="checkbox"/>	<b>Musculoskeletal:</b>	<b>Yes</b>	<b>No</b>
Dry eyes.....	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain .....	<input type="checkbox"/>	<input type="checkbox"/>
Tearing.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain/stiff joints.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ears, nose, mouth, throat:</b>	<b>Yes</b>	<b>No</b>	Neck pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss.....	<input type="checkbox"/>	<input type="checkbox"/>	Back pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears.....	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness.....	<input type="checkbox"/>	<input type="checkbox"/>
Earaches .....	<input type="checkbox"/>	<input type="checkbox"/>	<b>Neurological:</b>	<b>Yes</b>	<b>No</b>
Nasal Congestion.....	<input type="checkbox"/>	<input type="checkbox"/>	Headaches .....	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds.....	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>
Snoring .....	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo .....	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat .....	<input type="checkbox"/>	<input type="checkbox"/>	Seizures .....	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness.....	<input type="checkbox"/>	<input type="checkbox"/>	Memory problems.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory:</b>	<b>Yes</b>	<b>No</b>	Tremor .....	<input type="checkbox"/>	<input type="checkbox"/>
Cough .....	<input type="checkbox"/>	<input type="checkbox"/>	Weakness or numbness .....	<input type="checkbox"/>	<input type="checkbox"/>
Sputum .....	<input type="checkbox"/>	<input type="checkbox"/>	<b>Behavioral/Psych:</b>	<b>Yes</b>	<b>No</b>
Pneumonia.....	<input type="checkbox"/>	<input type="checkbox"/>	ADHD .....	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing .....	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety.....	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath .....	<input type="checkbox"/>	<input type="checkbox"/>	Depression.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular:</b>	<b>Yes</b>	<b>No</b>	Mood disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disturbances .....	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations.....	<input type="checkbox"/>	<input type="checkbox"/>	<b>Endocrine:</b>	<b>Yes</b>	<b>No</b>
Irregular heartbeat.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Pass out or faint.....	<input type="checkbox"/>	<input type="checkbox"/>	Poor wound healing.....	<input type="checkbox"/>	<input type="checkbox"/>
Swelling in ankles/feet.....	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst.....	<input type="checkbox"/>	<input type="checkbox"/>
Bruise easily .....	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Gastrointestinal:</b>	<b>Yes</b>	<b>No</b>	<b>Other:</b>	<b>Yes</b>	<b>No</b>
Trouble swallowing.....	<input type="checkbox"/>	<input type="checkbox"/>	HIV .....	<input type="checkbox"/>	<input type="checkbox"/>
Reflux.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A .....	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting .....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B .....	<input type="checkbox"/>	<input type="checkbox"/>
Constipation.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C .....	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>			
Blood in stool.....	<input type="checkbox"/>	<input type="checkbox"/>			
Abdominal pain.....	<input type="checkbox"/>	<input type="checkbox"/>			

**Women Only:**

	Yes	No		Yes	No
Heavy menstrual bleeding .....	<input type="checkbox"/>	<input type="checkbox"/>	Discharge from Nipples .....	<input type="checkbox"/>	<input type="checkbox"/>
Tender Breasts .....	<input type="checkbox"/>	<input type="checkbox"/>	Fibrocystic Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Lump or recent change in size .....	<input type="checkbox"/>	<input type="checkbox"/>	Previous Mammogram (Year: _____)	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual problems .....	<input type="checkbox"/>	<input type="checkbox"/>	Were your children breast fed? .....	<input type="checkbox"/>	<input type="checkbox"/>
Birth Control Pills .....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have breast implants? .....	<input type="checkbox"/>	<input type="checkbox"/>
Number of Pregnancies _____			Other implants? .....	<input type="checkbox"/>	<input type="checkbox"/>
Number of Live Births _____			Multiple Miscarriages .....	<input type="checkbox"/>	<input type="checkbox"/>
Bra Size _____					

**Family History:**

	Yes	No		Yes	No
Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>
Relation: _____			Low Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>
Type of Cancer: _____			Blood Disorders (i.e. Sickle Cell anemia, etc.) .....	<input type="checkbox"/>	<input type="checkbox"/>
Relation: _____			Bleeding Tendency .....	<input type="checkbox"/>	<input type="checkbox"/>
Type of Cancer: _____					
Other: _____ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

**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