REGENESIS
PLASTIC SURGERY AND SKIN CARE CENTER
2643 Patterson, Suite 506 ✻ St. Mary's Physician's Tower ✻ Grand Junction, Colorado 81506 ✻ 970-242-8177 ✻ fax: 970-255-3558

Date _____

Confidential Health Questionnaire for Body Contouring

(Includes liposuction, tummy tuck, armlift, thighlift and bodylift)

Patient Name _____ Date of Birth _____ Age _____

Primary Care Physician _____ Referring Physician _____

Reason for visit _____

Which areas are of concern to you?

- □ Neck
- □ Arms
- □ Breasts
- □ Abdomen
- □ Stretch marks in abdomen
- □ Flanks (love handles)
- □ Front of thighs
- □ Back of thighs
- □ Inner thighs
- □ Outer thighs (saddle bags)
- □ Knees

What symptoms do you have?

- □ Skin Irritation
- □ Chafing
- □ Infections
- □ Pain
- □ Hygiene problems
- □ Back pain

What have you attempted to help with these symptoms? _____

Have you undergone weight loss surgery? □ Yes □ No

Date of Surgery: _____ Amount of Weight loss: _____

Surgeon: _____ How long have you been at your current weight?_____

MEDICAL INFORMATION

Allergies □ None □ Penicillin □ Latex □ Sulfa □ Iodine □ Codeine

DRUG:	REACTION:
□ _____	_____
□ _____	_____
□ _____	_____

Medications (including dietary supplements, nonprescription and herbal products)

NAME:	DOSAGE:	FREQUENCY:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

Surgeries: (Please list all previous surgeries including approximate date)

1._____ 4._____

2._____ 5._____

3._____ 6._____

Has the patient ever had a serious reaction to anesthesia? □ No □ Yes:_____

Social History

Current Occupation: _____

Marital Status: □ Single □ Married □ Divorced □ Legally Separated □ Widowed □ Other

Do you smoke or chew tobacco? □ Never □ Some Days □ Daily □ Former Smoker
How many packs per day?_____ When did you quit?_____

Do you drink alcohol? □ No □ Rarely □ Weekly □ Daily

Do you use recreational drugs? □ No □ Yes:_____

Review of Systems (Current symptoms)

GENERAL:
□ Anorexia
□ Appetite Loss
□ Chills
□ Excessive Crying
□ Fatigue
□ Fever
□ Significant Weight Change

SKIN:
□ Bruising
□ Change in Wart/Mole
□ Excessive Sweating
□ New Lesion
□ Rash

HEENT:
□ Dentures
□ Difficulty swallowing
□ Nose bleeds
□ Headaches
□ Recurrent sinusitis
□ Hearing loss
□ Ear Drainage
□ Ear Pain
□ Dizziness
□ Wears glasses
□ Wears contacts
□ Glaucoma
□ Facial numbness/tingling
□ Trouble opening mouth

NECK:
□ Mass
□ Pain
□ Swollen glands
□ Stiffness

RESPIRATORY:
□ Wheezing
□ Bronchitis
□ Pneumonia
□ Shortness of Breath
□ Constant cough

CARDIOVASCULAR:
□ Low blood pressure
□ Chest pains
□ Irregular heart beat

BREAST:
□ Mass
□ Pain
□ Swelling
□ Discharge
□ Gynecomastia
□ Skin Changes

GASTROINTESTINAL:
□ Urinary infections
□ Heartburn
□ Colitis
□ Chronic diarrhea
□ Jaundice
□ Pancreatitis
□ Hernia

MUSCULOSKELETAL:
□ Arthritis
□ Rheumatoid Arthritis
□ Limited joint motion
□ Muscle weakness

BLOOD:
□ Anemia
□ Sickle cell disease/trait
□ Easily bruised

NEUROLOGICAL:
□ Numbness or Tingling
□ Head injury

PSYCHOLOGICAL:
□ Depression
□ Anxiety
□ Other Mental problem_____

OTHER:
□ Fibromyalgia

Family Medical History (Please explain if any of these conditions have affected a blood relative)

□ Cancer □ Breast Disease □ Heart disease □ Diabetes □ Bleeding problem □ Reaction to anesthesia

Medical Illnesses: (This applies to the patient. If yes, please explain)

EYES:
□ Glaucoma
□ Vision loss/blindness

STOMACH/INTESTINAL:
□ GERD □ Ulcers
□ Other:_____

LUNGS/RESPIRATORY:
□ Asthma
□ Obstructive Sleep Apnea □ CPAP
□ COPD/emphysema/chronic bronchitis
□ Pneumonia
□ Tuberculosis
□ Other:_____

HEART:
□ High blood pressure □ High cholesterol
□ Heart murmurs □ Heart Valve Problem
□ Irregular or rapid heart beat
□ Coronary heart disease
□ Congestive heart failure
□ Heart attack year:_____
□ Implanted pacemaker or defibrillator
□ Other:_____

NEUROLOGICAL:
□ Stroke □ Seizures/Epilepsy
□ TIA (transient ischemic attacks)
□ Multiple Sclerosis
□ Other:_____

MUSCLE/JOINT:
□ Arthritis
□ Fractures:_____

URINARY/BLADDER PROBLEMS:
□ Stress/urge incontinence
□ Frequent urinary tract infections
□ Gynecological problems
□ Other:_____

ENDOCRINE DISORDERS:
□ Thyroid disease (hyper/hypo)
□ Diabetes mellitus
□ Osteoporosis/Osteopenia

IMMUNE SYSTEM/INFECTIONS:
□ AIDs or HIV positive
□ Hepatitis □ Jaundice or liver disease

PSYCHOLOGICAL DISORDERS:
□ Depression □ Anxiety
□ Other:_____

CANCER:
□ Breast □ Lung □ Thyroid □ Prostate □ Kidney
□ Brain □ Skin □ Other:_____

BLOOD DISORDERS:
□ History of blood clots (DVT or PE)
□ Coumadin Therapy □ Aspirin □ Plavix

How did you hear about ReGenesis Plastic Surgery and Skin Care Center?

□ Internet search □ Doctor □ Friend □ Other _____
□ Television □ Magazine

Who can we thank for this referral? _____

Completed by _____

Signature _____

Section below to be completed by physician

I have read & reviewed
Physician's Signature _____