

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 Breast Augmentation

Patient Name _____ Date of birth _____ Age _____

Primary Care Physician _____ Referring Physician _____

Reason for visit _____

Current bra size _____ Desired bra size _____

Have you had a mammogram? No Yes: _____
If yes, please give date and result

Have you had a physician examine your breasts? No Yes: _____
If yes, please give date and result

Do you perform a regular breast self exam? No Yes: _____
If yes, have you found any abnormalities?

Have you had any problems with your breast? No Yes: _____
If yes, please give date and details

Has anyone in your family had breast problems? No Yes: _____
If yes, please give details

MEDICAL INFORMATION

Allergies None Penicillin Latex Sulfa Iodine Codeine

DRUG:	REACTION:
<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____	_____

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 _____