OHSU Plastic and Reconstructive Surgery New Patient Questionnaire

Preferred Name _____

Preferred Pharmacy:_____

Pharmacy Phone Number:_____

Please take a few moments to tell us about yourself:

How many people live at home with you? _____

What is your occupation? _____

Do you smoke/chew tobacco?

❒Current User Amount_____ ❒ Quit Date_____ ❒Non-Smoker

Current or History of recreational drug use? ❒ No ❒ Yes _____

Do you drink alcohol? ❒ No ❒ Yes _____ drinks per week

Please take a few moments to tell us about your health:

❒ I am an OHSU patient please see attached sheet for Allergies and Medication(s)

ALLERGIES: e.g. Medications, iodine, foods, anesthesia, tape, etc.

Food/Drug	**Reaction**
_____	_____
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS: Please include ***herbal supplements*** or ***over-the-counter*** remedies, ***birth control***

Name of Drug	**Dose (mg)**	**How Often Taken**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OFFICE USE ONLY:

Ht: _____ Wt: _____ SpO2: ____ BP: _____ P: _____ R: _____

MEDICAL PROBLEMS: Any medical ***illnesses/problems*, *accidents* or *injuries*** as an ***infant*, *child* or *adult***. Please include those problems for which you are taking medications and congenital or birth events

_____	_____
_____	_____
_____	_____
_____	_____

Do you have history of:

			If yes, please specify
Heart, lung, or kidney problems?	Yes ❒	No ❒	_____
Cancer, including skin cancer?	Yes ❒	No ❒	_____
Hepatitis, liver disease?	Yes ❒	No ❒	_____
HIV/AIDS?	Yes ❒	No ❒	_____
MRSA infections?	Yes ❒	No ❒	_____
Bleeding easily or blood clots?	Yes ❒	No ❒	_____
Problems with anesthesia?	Yes ❒	No ❒	_____
Blood Clot: Legs or Lungs	Yes ❒	No ❒	_____
Women Only: Mammogram	Yes ❒	No ❒	Date of last_____

PREVIOUS SURGERIES:

Procedure	**Year**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY: Please list any medical conditions that run in your family

Illness	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

REVIEW OF SYSTEMS:

Please check if you have experienced any of these conditions within the last month.

General:

__ Unexpected weight loss
__ Fever
__ Chills
__ Hot flashes
__ Depression
__ Anxiety
__ Memory problems
__ Stress
__ Rashes
__ Sores
__ Lumps
__ Fainting
__ Headaches, seizures, head injury

__ Breast lumps/pain
__ Moles
__ Breast skin changes
__ Nipple discharge
__ Possibly pregnant
__ Testicular pain/lump

__ Hearing loss
__ Dizziness
__ Ear ache

__ Loss of vision glaucoma, cataracts
__ Double vision
__ Runny nose
__ Stuffiness
__ Dentures
__ Bleeding gums
__ Sores in mouth
__ Missing teeth
__ Hoarseness
__ Sore throat
__ Difficulty swallowing

__ Chest pain
__ Chest Palpitations
__ Leg swelling
__ Discoloration of your legs
__ Blood clot in legs or lungs
__ Leg pain with exertion
__ Bleeding tendencies
__ Anemia
__ Purple spots on skin

__ Shortness of breath
__ Asthma/wheezing
__ Cough

How many flights of stairs could you climb before becoming winded? □ 0, □ 1, □ 10, □ >10

__ Nausea
__ Vomiting
__ Diarrhea
__ Heartburn/indigestion
__ Blood in stools
__ Abdominal pain
__ Yellow skin
__ Frequent urination
__ Painful urination
__ Kidney problems

__ Numbness
__ Tingling
__ Paralysis

Muscles/Bones:

__ Weakness __ Joint pain __ Limited motion __ Arthritis __ Instability
__ Gout __ Swelling/redness