ARIC J. ECKHARDT, M.D., F.A.C.S.
Plastic & Reconstructive Surgery

HEALTH QUESTIONNAIRE

Please describe your complaint or why you are here: ____________________

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Past Medical History:

Height____________ Weight____________ Any weight loss?____________ How much? __________

PREVIOUS SURGERY (Please list)

Operation	Year	Complications

SERIOUS INJURIES (Please list)

Type	Year	After Effects

MEDICATIONS, DRUGS

Please list ALL medications you are now taking (including birth control pills, diuretics/water pills), blood pressure or heart medications, tranquilizers, hormones, steroid medications, cortisone, blood thinners, aspirin, ibuprofen, etc.

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GENERAL HISTORY

Have you ever been pregnant? Yes______ No______ If yes, how many times?____________
How many children do you have?_______ Are you now pregnant?_________

			If yes, please comment
Are you allergic to any pills, drugs or medications?	Yes_____	No_____	____________
Do you have any other known allergies?	Yes_____	No_____	____________
Have you ever had a bad reaction to a general anesthesia?	Yes_____	No_____	____________
Have you ever had a bad reaction to a local Anesthesia	Yes_____	No_____	____________

(CONTINUED ON BACK OF PAGE)

Do you have high blood pressure?	Yes_____	No_____	__________
Do you bleed unusually easily? (from cuts, surgery)?	Yes_____	No_____	__________
Do you form large scars or keloids?	Yes_____	No_____	__________
Do you have frequent infections or boils?	Yes_____	No_____	__________
Have you ever had any significant emotional problem?	Yes_____	No_____	__________
Have you ever had psychiatric care?	Yes_____	No_____	__________
Have you ever been advised to see a psychiatrist?	Yes_____	No_____	__________
Have you seen other plastic surgeons about the SAME problem which brings you here?	Yes_____	No_____	__________

I consent to the taking and publication of any photographs in the course of any evaluation/consultation/surgical procedure for the advancing of medical education. I realize that my identity may be revealed by such photographs or by the descriptive text accompanying them.

__________ Date

__________ Signature of Patient or Guardian