

## Washington Plastic Surgery, PLLC Health Questionnaire

Yes	No		Yes	No	
_____	_____	Recent Illness (<Yr)	_____	_____	High Blood Pressure
_____	_____	Cough, Cold, Flu	_____	_____	Stomach Ulcer
_____	_____	Nose Obstruction	_____	_____	Heart Surgery
_____	_____	Shortness of Breath	_____	_____	Excessive Bleeding
_____	_____	Lung Disease	_____	_____	Anemia
_____	_____	Asthma	_____	_____	Coronary Artery Disease
_____	_____	Emphysema/COPD	_____	_____	Stroke
_____	_____	Heart Trouble	_____	_____	Seizure/Epilepsy
_____	_____	Angina	_____	_____	Psychiatric Treatment
_____	_____	Heart Attack	_____	_____	Liver Disease
_____	_____	Irregular Heart Beat	_____	_____	Steroid Use
_____	_____	Pacemaker	_____	_____	Jaundice
_____	_____	Heart Murmur	_____	_____	Hepatitis
_____	_____	Stomach Ulcer	_____	_____	Cancer
_____	_____	Dentures	_____	_____	Diabetes
_____	_____	Arthritis	_____	_____	Kidney Disease
_____	_____	Artificial Joints	_____	_____	Infectious Disease
_____	_____	TB	_____	_____	Sleep Apnea

Do you wear glasses or contact lenses? \_\_\_\_\_ Result of last vision test: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight Range for Last 5 years \_\_\_\_\_ to \_\_\_\_\_

Do you have children? (Ages) \_\_\_\_\_

Please list all surgeries and dates:  
\_\_\_\_\_  
\_\_\_\_\_

History of any adverse anesthetic episodes: \_\_\_\_\_

History of excessive bleeding during surgery: \_\_\_\_\_

History of poor scarring or wound healing: \_\_\_\_\_

History of serious illness in your family: Please List \_\_\_\_\_

Medication **Allergies** \_\_\_\_\_

Please list all medications and or vitamins that you are currently taking \_\_\_\_\_  
\_\_\_\_\_

Daily Consumption of: Tobacco \_\_\_\_\_ If quit – when \_\_\_\_\_ Alcohol \_\_\_\_\_ Aspirin/NSAIDS \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ If yes, how many weeks \_\_\_\_\_

History of Breast Disease: \_\_\_\_\_ Please explain \_\_\_\_\_

Date of Last Mammogram and Result \_\_\_\_\_

Any other information that you feel may be important for your care \_\_\_\_\_