BAYSIDE PLASTIC SURGERY- DR JOHN ROACH JR D.O.

MEDICAL HISTORY FORM

NAME _____ DOB _____ AGE_____
WEIGHT_____ HEIGHT_____ BLOOD PRESSURE _____ TEMP_____
ARE YOU LEFT OR RIGHT HANDED? _____
PRIMARY CARE DOCTOR _____ PHONE _____
WHO REFERRED YOU TO US? _____

DESCRIBE PRESENT SYMPTOMS/COMPLAINTS: _____
_____
WHEN DID THIS PROBLEM BEGIN? _____
Is this a work-related problem or is an attorney helping you with your problem? _____

*Please list all prior surgeries:
_____
_____

*Please list all medications: (If you have a list we will gladly make a copy)
_____
_____
_____

*Medical Conditions: _____
*Allergies: _____
*Have you had a recent flu or pneumonia shot (Y) or (N) If yes: Month ____ Year _____
*Smoking history, please circle one: (current smoker) (nonsmoker) (former smoker)
*Alcohol history, please circle one: (never) (social) (moderate to heavy)
* History of drug abuse (Y) or (N) if yes, what _____

REVIEW OF SYSTEMS

Please circle anything that pertains to your health:
CONSTITUTIONAL: *fever chills fatigue weightloss/gain*
PSYCHIATRIC: *anxiety depression mood swings difficulty sleeping homicidal/suicidal thoughts*
NEUROLOGICAL: *headaches memory loss loss of strength paralysis numbness*
RESPIRATORY: *cough wheezing congestion shortness of breath*
EAR,NOSE,THROAT: *sore throat sinus trouble stuffy nose hearing loss nosebleeds*
CARDIOVASCULAR: *chest pain dizziness high blood pressure palpitations*
GASTROINTESTINAL: *heartburn/reflux nausea/vomiting abdominal pain constipation diarrhea*
MUSCULOSKELETAL: *joint pain stiffness muscle pain back/neck pain*
HEMATOLOGY: *anemia easy bruising/bleeding enlarged glands*
GYNECOLOGIC: *pregnant nursing trying to get pregnant hormone replacement therapy*
SKIN: *rash sores new/changing lesions itching/burning*
ENDOCRINE: *diabetes loss of hair heat/cold intolerance*
GENITOURINARY *frequent urination painful urination blood in urine bladder leakage*

FAMILY HISTORY

Any family history of (please circle all that applies and if yes, please list who)
Cancer _____ diabetes _____ high blood pressure_____
Heart disease _____ Other_____