History and Physical Examination

Plastic and Reconstructive Surgery

Drs Stadelmann, Tobin, and Weiner

Name: Date:

Age: Birthday: Social Security #:

Family Physician: Referred By:

Why are you here to see Dr Stadelmann?

Allergies to medications:

Present Medications:

Past Medical Problems:

Past Operations (Describe and Give Dates and Doctors involved):

Family History of:

Cancer (what type and in whom):
Heart Disease:
Breast Disease/Cancer:
Diabetes: High
Blood Pressure:
Other?:

Social:

How do you make a living?:
Tobacco:
Alcohol:
Blistering Sunburns as a child?:
Heavy sunlight exposure:
Do you use tanning beds?:

Date of Your Last Mammogram: Results:
Date of Your Last PAP Smear: Results:
Number of Times Pregnant: Number of Children:

History and Physical Examination
Plastic and Reconstructive Surgery
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General Health:

Weight loss	YES	NO
Night sweats	YES	NO
Fever/chills	YES	NO
Weakness	YES	NO

Head and Neck Area

Vision Change	YES	NO
Head Aches	YES	NO
Swollen glands	YES	NO
Nose Bleeds	YES	NO
Change in taste/smell	YES	NO
Hearing Loss	YES	NO
Thyroid problems	YES	NO

Gastrointestinal:

Jaundice	YES	NO
Abdominal pain	YES	NO
Nausea/vomiting	YES	NO
Vomit blood	YES	NO
Blood in stool	YES	NO
Difficulty swallowing	YES	NO
Severe heartburn	YES	NO
Constipation	YES	NO
Jaundice	YES	NO

Heart:

Chest pain	YES	NO
Heart attack	YES	NO
Irregular heart rate	YES	NO
Heart failure	YES	NO
Swelling in ankles	YES	NO

Musculoskeletal:

New pain in bones	YES	NO
Arthritis	YES	NO

Breast:

Lumps /cysts	YES	NO
Nipple discharge	YES	NO
Pain	YES	NO

Blood System:

Anemia	YES	NO
Easy bruising	YES	NO
Clotting problems	YES	NO
Blood clots in legs	YES	NO
Blood thinners	YES	NO

Skin:

Rashes	YES	NO
Skin cancer	YES	NO
Change in a mole	YES	NO

Kidney:

Blood in urine	YES	NO
Kidney/Bladder	YES	NO
Infection	YES	NO
Kidney stones	YES	NO
Painful urination	YES	NO
Difficulty urinating	YES	NO

Lungs:

Lung problems	YES	NO
Shortness of breath	YES	NO
Coughing up blood	YES	NO
Wheezing /asthma	YES	NO
Pneumonia	YES	NO
Tuberculosis	YES	NO

Psychiatric:

Depression	YES	NO
Anxiety	YES	NO
Mood swings	YES	NO

Neurologic:

Tingling	YES	NO
Numbness	YES	NO
Weakness	YES	NO

Immune System:

HIV positive	YES	NO
Ever tested	YES	NO

History reviewed with the patient:

(Signature)_______________________________________