# Wendy-Ann M Olivier, MD

## Plastic & Reconstructive Surgery

## History Form

| Last Name: | First Name: | E-Mail: |
|---|---|---|
| Date of Birth: | Home Phone: | Mobile Phone: |

Please list ***SPECIAL PROBLEMS*** you would like evaluated today in order of significance:

**1.**

**2.**

**3.**

**4 .**

| ***MEDICATION ALLERGIES:*** (such as penicillin) What happens when you take that medicine: | ***OTHER ALLERGIES:*** (such as bees/wasps, foods, latex, etc) What happens when you are exposed: |
|---|---|
| ***PHARMACY NAME:*** | ***PHARMACY PHONE NUMBER:*** |

***MEDICATIONS:***

Prescription and Non-Prescription
(including aspirin, vitamins, birth control, herbs, supplements, etc.)

***PAST MEDICAL HISTORY***

Please describe and give dates of any illnesses, injuries, hospitalizations, and surgeries:

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### *FAMILY HISTORY*

Please check any family members who have the following health problems.

| | Father | Mother | Brother | Sister | Grandparent | Other |
|---|---|---|---|---|---|---|
| Diabetes | | | | | | |
| Glaucoma | | | | | | |
| Cancer (List type) | | | | | | |
| Heart attack | | | | | | |
| Angina | | | | | | |
| Stroke | | | | | | |
| High blood pressure | | | | | | |
| High cholesterol | | | | | | |
| Alcoholism | | | | | | |
| Drug Abuse | | | | | | |
| Depression | | | | | | |
| Mental Illness | | | | | | |
| Suicide | | | | | | |
| Other health problems | | | | | | |

### *SOCIAL HISTORY*

| | |
|---|---|
| Spouse's Name: | Spouse's Occupation: |
| Ages of Children: | # of People in Household: |
| Your Occupation: | Place Employed: |
| Level of Education: | Hobbies: |

Recent Significant Changes in Your Life? Yes No

Financial Hardships? Yes No

Have Special Stresses in Your Life? Yes No

I am **NOT** happy with (circle those that apply) → Myself My Health My Work My Partner My Life

Have you ever used **tobacco products** regularly? Yes__ No__ if yes, please continue below:

| Tobacco Product | Age Started Using | # of years used? | Amount each day | Still Use? |
|---|---|---|---|---|
| | | | | |

Circle the **beverages** you regularly consume and list the amount per WEEK:

Coffee/Tea: Beer: Wine: Hard liquor: Soda:

### *CURRENT HEALTH PRACTICES*

**Food, exercise, and safety can all play a role in your health.**
**Please answer the following questions to see what areas might put you at risk.**

Do you exercise regularly? yes / no Type of exercise and frequency:

How many meals do you eat per day? Snacks per day?

How many meals do you eat out per week?

Amount and type of **dairy products** you consume per day:

List any nutrition or diet concerns you would like help with:

If you are on a **special diet**, please explain:

Are you happy with your weight? Yes No

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***REVIEW OF SYSTEMS:***

Circle those items you currently have significant problems with, and describe:

| | | |
|---|---|---|
| **GENERAL** | | |
| Recent Weight Change | Increased Thirst or Urination | Night Sweats/Hot Flashes |
| Always Hot/Always Cold | Rashes or Skin Problems | Significant Fatigue |
| Do you have chronic pain problems? Yes No | | |
| **BREASTS: Men & Women** | | |
| Lumps/Tenderness | Do You Do Monthly Self Breast Exams? Y__N__ | |
| Drainage from Nipple | Month and Year of Last Mammogram:_____ | |
| **EYE, EAR, NOSE, AND THROAT** | | |
| Glaucoma | Blurred or Double Vision- Ever | Use Glasses or Contact Lenses |
| Hearing Loss | Brief Loss of Vision- Ever | Use Dentures (Partial or Total) |
| History of Radiation Therapy to Head or Neck | | Teeth or Gum Problems |
| **CARDIOPULMONARY** | | |
| Shortness Of Breath With Activity | Dizziness | Chest Pain |
| Daily Sputum (Phlegm) Production | Coughing Up Blood | Heart Palpitations |
| Difficulty Breathing While Lying Flat | Leg Cramps While Walking | Wheezing |
| Waking Up Short of Breath | Daily Cough | Ankle Swelling |
| **GASTROINTESTINAL** | | |
| Change of Appetite | Abdominal Pain | Blood in Stool/Black Stool |
| Difficulty Swallowing | Diarrhea/Constipation | Frequent Nausea/Vomiting |
| Heartburn | Indigestion From Fatty Foods | |
| **NEUROPSYCHIATRIC** | | |
| Frequent Disabling Headaches | Difficulty Sleeping | Tremors |
| Frequent Anxiety or Anxiety Attacks | Memory Loss | Passing Out/Fainting |
| Treated in Past for Emotional or Psychological Problems: please describe _____ | | Often Feel Sad or Depressed |
| **MUSCULOSKELETAL & SKIN** | | |
| Frequent Neck or Back Pain | Muscle Pain | Disabling Night Leg Cramps |
| Joint Problems | Use a Brace or a Splint | |
| Mole that has changed color, size, shape, or won't heal? Yes No | | |
| **GENITOURINARY: MEN & WOMEN** | | |
| Urinary Tract Infections | Sores in the Genital Area | |
| Difficult or Painful Urination | Blood in Urine | |
| History of Kidney or Bladder Stones | Urination More Than Once a Night | |
| History of Four or More Sex Partners | Sexual Intercourse Before 18 years old | |
| Method of Birth Control: | | |
| Have you ever had any Sexually Transmitted Disease: Yes___ No___<br>if yes, please describe: | | |
| **GENITOURINARY: MEN ONLY** | | |
| Pain or Lump in Testicles/Scrotum | Do you do Self Testicular Exam: Yes___ No ___ | |
| **GENITOURINARY: WOMEN ONLY** | | |
| Age of first Period | Frequency/Length of Menstrual Periods: _____ | |
| Date of Last Menstrual Period: _____ | Change in Menstrual Pattern | |
| Number of Pregnancies: _____ | Number of Children: _____ | |
| Disabling Menstrual Cramps | Unusual Vaginal Discharge/Itching | |
| Date of Last Pap Smear: _____ | | |
| History of Abnormal Pap Smear: Y N | Any Treatments for Abnormal Pap: | |

**To the best of my knowledge, this is an accurate statement of my health:**

**Signature:_____ Date: _____**