Derek Jones M.D.
FACIAL PLASTIC SURGERY℠

Medical Center / Clinic℠
HEALTHCARE CENTERED AROUND YOU

# GENERAL QUESTIONNAIRE

Your Name: _____

Your answers to the following questions will help us with your treatment. **Please answer each question as completely and accurately as you can.** If you are unsure about a question, please ask one of our medical staff to clarify it.

**1.** Briefly describe why you are seeing the doctor today: _____

_____

_____

_____

**2.** How long have you had this problem? _____

**3.** Were you referred by another physician? ☐ Yes ☐ No

Referring Physician's Name: _____
Address: _____

If you have a primary care physician, who is **not** the referring physician, please provide us with:

Primary Care Physician's Name: _____
Address: _____

## MEDICAL HISTORY

**4.** Have you **ever** had any of the following? (Please check all that apply.)

| | | | |
|---|---|---|---|
| ☐ High Blood Pressure | ☐ Heart Attack | ☐ Abnormal Heart Rhythm | ☐ Stroke |
| ☐ Heart Failure | ☐ Heart Murmur | ☐ Seizures | ☐ Asthma |
| ☐ Syncope / Fainting Spells | ☐ Kidney Disease | ☐ Liver Disease / Jaundice | |
| ☐ Cancer Type(s): _____ | | | |
| ☐ Hepatitis | ☐ Thyroid Problems | ☐ Pneumonia | ☐ Anemia |
| ☐ Tuberculosis (TB) | ☐ Arthritis | ☐ Acid Reflux | ☐ Latex Allergy |
| ☐ Diabetes | ☐ Blood Transfusion | ☐ Bleeding Problems | ☐ Depression |
| ☐ Radiation Treatment | ☐ Substance Abuse | ☐ Deep Vein Thrombosis / Blood Clots | |

Other conditions you have been treated for: _____

_____

_____

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## **MEDICAL HISTORY** (continued)

**5.** Have you ever had any of the following surgeries? (Place approximate date of surgery in blank.)

Tonsillectomy and/or Adenoidectomy_____ Thyroidectomy_____
Tympanostomy (Ear tubes)_____ Knee or Hand Surgery (Circle)_____
Nose or Sinus Surgery_____ Neck or Back Surgery (Circle)_____
Open Heart Surgery_____ Wisdom Teeth Extracted_____
Gall Bladder_____ Hysterectomy_____
Other ENT Surgery_____ (Please list) _____

Please list all other surgeries:_____

Have you ever had problems with anesthesia? ☐ Yes ☐ No

**6.** Are you allergic to any medications? ☐ Yes (List below) ☐ No

**7.** Medications you are currently taking (Also include non-prescription medications, such as aspirin, herbal treatments, and vitamins that you take on a regular basis): ☐ No Medications

| **Medication Name** | **Reason for Taking** |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

(For additional medications, please write on the back of this page or provide a complete list.)

**8.** Are your immunizations / vaccinations up to date? ☐ Yes ☐ No

## **SOCIAL HISTORY**

**9.** Your Occupation:_____

**10.** Your Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

**11.** Do you have a child/children? ☐ Yes ☐ No In Daycare? ☐ Yes ☐ No

**12.** Do you live alone? ☐ Yes ☐ No If no, who lives with you?_____

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## **SOCIAL HISTORY** (continued)

**13.** Do you smoke? ☐ No, I never smoked

☐ No, I quit _____ years ago. At that time, I was smoking pack(s) per day for _____ years

☐ Yes, I've smoked _____ packs of cigarettes per day for _____ years

☐ Yes, I smoke cigars or a pipe

Are you exposed to smoke from other members of your family on a daily basis? ☐ Yes ☐ No

**14.** Do you drink alcohol? ☐ No, never (or rarely) ☐ No, but I used to

☐ Yes, daily ☐ Yes, 1 or more times a week ☐ Yes, 1 or more times a month

Have you had a problem with alcoholism? ☐ Yes ☐ No

**15.** Are you at risk for AIDS / HIV / Hepatitis (E.g., sexual orientation, drug abuse, previous blood transfusions)? ☐ No ☐ Yes, please explain _____

_____

## **FAMILY HISTORY**

**16.** Do you have any **blood relatives** who have any of the following conditions? (Check all that apply):

☐ Heart Disease ☐ Problems with Anesthesia ☐ Diabetes ☐ Allergies
☐ High Blood Pressure ☐ Bleeding Problems ☐ Asthma ☐ Stroke
☐ Hearing Loss ☐ Cancer Type(s) _____

_____

## **CURRENT SYMPTOMS**

**17.** Please check all symptoms that you now have:

| | |
|---|---|
| **General:** | ☐ Fatigue ☐ Chills ☐ Fever ☐ Night Sweats ☐ Weight Loss/Gain |
| **Eyes:** | ☐ Change in Vision ☐ Double Vision ☐ Wear Glasses |
| **Ears:** | ☐ Hearing Loss ☐ Ear Pain ☐ Ear Drainage ☐ Ringing ☐ Dizziness |
| **Nose:** | ☐ Nasal Congestion ☐ Nasal Bleeding ☐ Nasal Drainage ☐ Sinus Pain |
| **Throat:** | ☐ Difficulty Swallowing ☐ Change in Voice ☐ Feel a Lump in Throat/Throat Pain |
| **Lungs:** | ☐ Shortness of Breath ☐ Frequent Cough ☐ Wheezing ☐ Coughing Blood |
| **Cardiovascular:** | ☐ Chest Pain ☐ Irregular Heartbeat ☐ Ankle Swelling |
| **Gastrointestinal:** | ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Vomiting Blood ☐ Abdominal Pain |

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## **CURRENT SYMPTOMS** (continued)

Please check all symptoms that you now have:

| | |
|---|---|
| **Genitourinary:** | ☐ Difficulty Urinating ☐ Blood In Urine |
| **Neurological:** | ☐ Depression ☐ Memory Loss ☐ Weakness ☐ Numbness ☐ Tingling |
| **Musculoskeletal:** | ☐ Back Pain ☐ Joint Pain ☐ Arm or Leg Pain ☐ Muscle Weakness |
| **Skin:** | ☐ Skin Cancer ☐ Skin Disease |
| **Endocrine:** | ☐ Increased Appetite ☐ Excessive Thirst ☐ Heat/Cold Intolerance |
| **Allergy/Immunology:** | ☐ Sneezing ☐ Itchy/Watery Eyes ☐ Facial Swelling ☐ Hives |

**18.** Age _____ Height _____ Weight _____

Approximate Blood Pressure _____

The above information is accurate to the best of my knowledge.

| Patient's signature | Date | Physician's signature |
|---|---|---|

**TO BE FILLED OUT BY THE NURSE:**