

**THE IOWA CLINIC / PLASTIC SURGERY  
5950 UNIVERSITY, SUITE 120  
WEST DES MOINES, IA 50266**

**GENERAL HEALTH HISTORY**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: M / F

PRIMARY DOCTOR: \_\_\_\_\_ REFERRING DOCTOR \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

WERE X-RAYS OR ANY OTHER TESTS TAKEN FOR THIS INJURY? Y / N \_\_\_\_\_

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING: CIRCLE YES OR NO

CONSTITUTION		NOSE/THROAT		MUSCULSKELETAL		CARDIOVASCULAR	
FEVER	Y / N	NOSEBLEEDS	Y / N	JOINT PAIN	Y / N	SHORT OF BREATH	Y / N
WEIGHT LOSS	Y / N	HOARSENESS	Y / N	SWELLING	Y / N	PALPITATIONS	Y / N
FATIGUE	Y / N	SORE THROAT	Y / N	<b>GI</b>		CHEST PAIN	Y / N
<b>EARS</b>		<b>EYES</b>		NAUSEA	Y / N	EXTREM SWELL	Y / N
PAIN	Y / N	GLAUCOMA	Y / N	VOMITING	Y / N		
DRAINAGE	Y / N	GLASSES	Y / N	DIFF SWALLOWING	Y / N		
HEARING PROBLEM	Y / N	CONTACTS	Y / N	HEARTBURN	Y / N	<b>OTHER</b>	
<b>SINUS</b>		<b>NEURO</b>		<b>HEMO/IMMUN</b>			
CONGESTION	Y / N	HEADACHES	Y / N	BRUISE EASILY	Y / N		
NASAL DRAINAGE	Y / N	DIZZINESS	Y / N	<b>SKIN</b>			
<b>COUGH</b>		UNSTEADINESS	Y / N	DISORDER	Y / N		
PRODUCTIVE	Y / N			LESIONS	Y / N		
NON-PRODUCTIVE	Y / N			MALIGNANCIES	Y / N		

HAVE YOU EVER HAD ANY OF THE CONDITIONS LISTED BELOW? CIRCLE YES OR NO

ASTHMA	Y / N	TUBERCULOSIS	Y / N	ULCERS	Y / N	KIDNEY PROB	Y / N
PNEUMONIA	Y / N	THYROID PROB	Y / N	HEPATITIS	Y / N	ANEMIA	Y / N
EMPHYSEMA	Y / N	ARTHRITIS	Y / N	HERNIA	Y / N	BLEEDING PROB	Y / N
HIGH BP	Y / N	SEIZURE	Y / N	STROKE	Y / N	OSTEOPOROSIS	Y / N
HEART CONDITION	Y / N	DIABETES	Y / N	MENTAL/ANXIETY DISORDER			Y / N
RECENT WT LOSS	Y / N	CURRENTLY PREGNANT	Y / N				
CANCER	Y / N	PLEASE STATE SITE OF CANCER	_____				

SURGERIES OR HOSPITALIZATIONS: \_\_\_\_\_

FAM HX: FATHER ALIVE/DECEASED AGE \_\_\_\_\_ MOTHER ALIVE/DECEASED AGE \_\_\_\_\_  
CAUSE OF DEATH \_\_\_\_\_ CAUSE OF DEATH \_\_\_\_\_

SOC HX: ALCOHOL USE: NEVER / RARE / MOD / HEAVY NICOTENE/TOBACCO USE: NEVER/QUIT  
SMOKE/CHEW/PATCH PACKS PER DAY: \_\_\_\_\_ X \_\_\_\_\_ YEARS

HAVE YOU EVER HAD GENERAL ANESTHESIA? Y / N If yes, did you have an adverse reaction? \_\_\_\_\_

ALLERGIES: \_\_\_\_\_ LATEX ALLERGY/SENSITIVITY (balloons, rubber, etc.) \_\_\_\_\_

CURRENT MEDICATIONS (including over-the-counter) \_\_\_\_\_

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

**CONSENT FOR MEDICAL ILLUSTRATION**

For the purpose of advancing medical knowledge, I hereby authorize and grant permission to authorized personnel to take and use photographs, drawings, and similar illustrative materials made of me. I authorize release of my photos to my insurance company if necessary.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENT OR LEGAL GUARDIAN, IF CHILD: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_