The Piazza Center
FOR PLASTIC SURGERY & ADVANCED SKIN CARE

Name: _____
DOB: _____
Date: _____


# Medical Questionnaire

**Height:** _____ **Weight:** _____
**Allergies to Medications?** ☐ No ☐ Yes: _____
**Current Medications:** ☐ None _____

**PHARMACY LOCATION:** _____
**PHARMACY PHONE:** _____
**Received COVID-19 Vaccine:** ☐ **Yes** Date:_____ ☐ No
**Manufacturer** ☐ **Pfizer** ☐ **Moderna** ☐ **J&J**
Dominant hand: ☐ Left ☐ Right ☐ Both

**Marital Status:**
☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ N/A
☐ Spouse / Sig. Other Name: _____ ☐ N/A
☐ Children-Ages: _____ ☐ N/A

| **Social History** | **Yes** | **No** |
|---|---|---|
| Do you currently smoke? | ☐ | ☐ |
| Have you ever used tobacco products? | ☐ | ☐ |
| How many packs per day? _____ How many years? _____ | | |
| Do you use alcohol? | ☐ | ☐ |
| Amount per week: _____ | | |
| Have you ever been treated for drug/alcohol problems? | ☐ | ☐ |
| Do you drink caffeinated beverages? (coffee, tea, pop) | ☐ | ☐ |
| How many per day: _____ | | |
| Do you feel safe where you are living now? | ☐ | ☐ |
| If no, do you want to talk to someone about this? | ☐ | ☐ |

**Past Medical History / Medical Problems (INCLUDE DATES)**

_____

**Prior Operations / Surgeries (INCLUDE DATES)**

**Review of General Systems**
Have you ever been diagnosed as having the following illnesses, or as having any of the following symptoms? If yes, state year.

| | | | | |
|---|---|---|---|---|
| Unusual fatigue | ☐ Yes | Yr _____ | ☐ No | |
| Unexplained change in weight | ☐ Yes | Yr _____ | ☐ No | |
| Recurrent fevers, chills, sweats | ☐ Yes | Yr _____ | ☐ No | |
| Increased thirst | ☐ Yes | Yr _____ | ☐ No | |
| Intolerance of heat or cold | ☐ Yes | Yr _____ | ☐ No | |
| Decreased appetite | ☐ Yes | Yr _____ | ☐ No | |
| Excessive thirst or appetite | ☐ Yes | Yr _____ | ☐ No | |
| Cancer | ☐ Yes | Yr _____ | ☐ No | |
| **Eyes** ☐ **No Concerns** | | | | |
| Vision changes | ☐ Yes | Yr _____ | ☐ No | |
| Pain / itching / drainage | ☐ Yes | Yr _____ | ☐ No | |
| Glaucoma | ☐ Yes | Yr _____ | ☐ No | |
| **Integumentary** ☐ **No Concerns** | | | | |
| Rash | ☐ Yes | Yr _____ | ☐ No | |
| Itching | ☐ Yes | Yr _____ | ☐ No | |
| Ulcers / Wounds | ☐ Yes | Yr _____ | ☐ No | |

**Review of Systems (Continued)**

| | | | | |
|---|---|---|---|---|
| **Ears, Nose and Throat** ☐ **No Concerns** | | | | |
| Sinus congestion | ☐ Yes | Yr _____ | ☐ No | |
| Sneezing | ☐ Yes | Yr _____ | ☐ No | |
| Hearing problems | ☐ Yes | Yr _____ | ☐ No | |
| Difficulty swallowing | ☐ Yes | Yr _____ | ☐ No | |
| Persistent sore throats | ☐ Yes | Yr _____ | ☐ No | |
| **Cardiovascular** ☐ **No Concerns** | | | | |
| High blood pressure | ☐ Yes | Yr _____ | ☐ No | |
| Low blood pressure | ☐ Yes | Yr _____ | ☐ No | |
| Heart attack | ☐ Yes | Yr _____ | ☐ No | |
| Chest pain | ☐ Yes | Yr _____ | ☐ No | |
| Racing heart | ☐ Yes | Yr _____ | ☐ No | |
| Shortness of breath at night | ☐ Yes | Yr _____ | ☐ No | |
| Swollen feet | ☐ Yes | Yr _____ | ☐ No | |
| Heart murmur | ☐ Yes | Yr _____ | ☐ No | |
| Leg cramps while walking | ☐ Yes | Yr _____ | ☐ No | |
| High cholesterol | ☐ Yes | Yr _____ | ☐ No | |
| Anemia | ☐ Yes | Yr _____ | ☐ No | |
| Rheumatic fever | ☐ Yes | Yr _____ | ☐ No | |
| Sickle cell disease | ☐ Yes | Yr _____ | ☐ No | |
| Blood transfusions and year | ☐ Yes | Yr _____ | ☐ No | |
| Any heart disease | ☐ Yes | Yr _____ | ☐ No | |
| **Respiratory** ☐ **No Concerns** | | | | |
| Shortness of breath | ☐ Yes | Yr _____ | ☐ No | |
| **C**ough | ☐ Yes | Yr _____ | ☐ No | |
| Coughing up phlegm / blood | ☐ Yes | Yr _____ | ☐ No | |
| Frequent chest colds | ☐ Yes | Yr _____ | ☐ No | |
| Wheezing, difficulty breathing | ☐ Yes | Yr _____ | ☐ No | |
| Asthma/Bronchitis/Emphysema | ☐ Yes | Yr _____ | ☐ No | |
| **Gastrointestinal** ☐ **No Concerns** | | | | |
| Heartburn | ☐ Yes | Yr _____ | ☐ No | |
| Bloating | ☐ Yes | Yr _____ | ☐ No | |
| Abdominal pain | ☐ Yes | Yr _____ | ☐ No | |
| Nausea / Vomiting | ☐ Yes | Yr _____ | ☐ No | |
| Ulcer | ☐ Yes | Yr _____ | ☐ No | |
| Hernia | ☐ Yes | Yr _____ | ☐ No | |
| Diarrhea | ☐ Yes | Yr _____ | ☐ No | |
| Constipation | ☐ Yes | Yr _____ | ☐ No | |
| Laxative use | ☐ Yes | Yr _____ | ☐ No | |
| Black / Bloody stools | ☐ Yes | Yr _____ | ☐ No | |
| Liver disease / Hepatitis | ☐ Yes | Yr _____ | ☐ No | |
| Weight loss, how much? | ☐ Yes | Yr _____ | ☐ No | |
| **Neurological** ☐ **No Concerns** | | | | |
| Headaches | ☐ Yes | Yr _____ | ☐ No | |
| Frequency | ☐ Yes | Yr _____ | ☐ No | |
| Numbness | ☐ Yes | Yr _____ | ☐ No | |
| Tremors | ☐ Yes | Yr _____ | ☐ No | |
| Sleep problems | ☐ Yes | Yr _____ | ☐ No | |
| Seizures / Stroke | ☐ Yes | Yr _____ | ☐ No | |

Depression/Anxiety/Mood Chgs ☐ Yes Yr _____ ☐ No

**Genitourinary** ☐ **No Concerns**

| | | |
|---|---|---|
| Flank pain | ☐ Yes Yr _____ | ☐ No |
| Pain during urination | ☐ Yes Yr _____ | ☐ No |
| Incontinence (loss of urine) | ☐ Yes Yr _____ | ☐ No |
| Frequent bladder infections | ☐ Yes Yr _____ | ☐ No |
| Kidney disease | ☐ Yes Yr _____ | ☐ No |

**Endocrine / Metabolic** ☐ **No Concerns**

| | | |
|---|---|---|
| Diabetes Type I | ☐ Yes Yr _____ | ☐ No |
| Diabetes Type II | ☐ Yes Yr _____ | ☐ No |
| **Currently on insulin?** | ☐ Yes Yr _____ | ☐ No |
| Thyroid disease | ☐ Yes Yr _____ | ☐ No |

**Screenings** ☐ **No Concerns**

| | | |
|---|---|---|
| Last menstrual period | _____ | ☐ N/A |
| Last PAP | _____ | ☐ N/A |
| Last mammogram | _____ | ☐ N/A |
| Last prostate exam | _____ | ☐ N/A |
| Have you been tested for COVID-19 | _____ | ☐ N/A |
| Have you been tested for STDs | ☐ Yes Yr _____ | ☐ No |
| Have you been tested for HIV/AIDS | ☐ Yes Yr _____ | ☐ No |

**Heme / Lymph** ☐ **No Concerns**

| | | |
|---|---|---|
| Anemia | ☐ Yes Yr _____ | ☐ No |
| Bleeding tendency | ☐ Yes Yr _____ | ☐ No |
| Bruising | ☐ Yes Yr _____ | ☐ No |
| Swollen glands | ☐ Yes Yr _____ | ☐ No |
| History of clots in legs or arms | ☐ Yes Yr _____ | ☐ No |
| Swelling / fluid retention in arms or legs | ☐ Yes Yr _____ | ☐ No |

**Musculoskeletal** ☐ **No Concerns**

| | | |
|---|---|---|
| Back / Neck pain | ☐ Yes Yr _____ | ☐ No |
| Extremity/Joint pain/swelling/stiffness | ☐ Yes Yr _____ | ☐ No |
| Limitations of physical activity | ☐ Yes Yr _____ | ☐ No |

**Family History** ☐ **No Concerns**

| | | |
|---|---|---|
| Is your mother living? | ☐ Yes | ☐ No, cause of death and age: _____ |
| Is your father living? | ☐ Yes | ☐ No, cause of death and age: _____ |
| Family history of breast cancer? | ☐ Yes | ☐ No – who: _____ |
| Family history of ovarian cancer? | ☐ Yes | ☐ No – who: _____ |
| Family history of heart disease? | ☐ Yes | ☐ No – who: _____ |
| Family history of diabetes? | ☐ Yes | ☐ No – who: _____ |
| Family history of hypertension? | ☐ Yes | ☐ No – who: _____ |

Is there anything else that you would like us to know so that we might better meet your needs?

_____

_____

_____

**Preferred methods of learning?** ☐ Verbal ☐ Visual / Pictorial ☐ Demonstration ☐ Written

**Barriers to learning:**

| | | |
|---|---|---|
| Hearing | ☐ Yes | ☐ No _____ |
| Vision | ☐ Yes | ☐ No _____ |
| Speech | ☐ Yes | ☐ No _____ |
| Language/Cultural/Religious | ☐ Yes | ☐ No _____ |
| Physical/Cognitive limitations | ☐ Yes | ☐ No _____ |
| Psych-social / Stress | ☐ Yes | ☐ No _____ |

**Are you currently taking any of the following blood-thinning medications?**

| | | |
|---|---|---|
| **Aspirin?** | ☐ No | ☐ Yes, Last does when? _____ |
| **Plavix?** | ☐ No | ☐ Yes, Last does when? _____ |
| **Coumadin?** | ☐ No | ☐ Yes, Last does when? _____ |
| **Warfarin?** | ☐ No | ☐ Yes, Last does when? _____ |
| **Ibuprofen / NSAIDs?** | ☐ No | ☐ Yes, Last does when? _____ |

Time: _____ Date: _____ **Patient/Responsible Person Signature:** _____

Reviewed By: _____ Staff Signature: _____

Nurse Practitioner / M.D. Signature: _____