HEALTH AND WELLNESS QUESTIONNAIRE

MICHELLE M. EAGAN, MD

Name: _____ Date _____

Email: _____ Phone #: _____

Referral:_____

Y N We may contact you by phone or email.

Y N We may thank the person that referred you.

Date of Birth: _____ Age: _____ Weight: _____ Height: _____

Allergies: _____

Medications: _____

REASON FOR TODAY'S APPOINTMENT: _____

Please circle Yes or No for the following questions. If your response is Yes, please describe.

MEDICAL INFORMATION

Y N Weight loss or gain: ____ lbs _____

Y N Diabetes _____HgA1c_____

Y N Wound healing problems: difficulty healing wounds, keloids, hypertrophic scars; locations_____

Y N Arthritis or other rheumatologic or vascular disease _____

Y N Cancer of any sort _____

Y N Chest pain, palpitations, heart devices, Heart disease or any heart problems

_____

Y N HIGH BLOOD PRESSURE _____

Y N Thyroid, endocrine or hormonal problems _____

Y N Difficulty swallowing or change in your voice _____

Y N Eye problems, infections, or injuries _____

Y N Nasal problems, difficulty breathing, nose injuries _____

Y N Lung problems, pneumonia, TB, asthma, congestion, shortness of breath when walking up stairs, use of an inhaler or wheezing_____ _____

Y N Breast problems _____

Y N Stomach, intestinal, bowel, hemorrhoid, ulcers, bleeding or digestion problems _____

Y N Liver, gallbladder problems _____

Y N Kidney, bladder, or urinary problems _____

Y N Nervous disorder, depression (explain) _____

Y N Epilepsy, convulsions, seizures _____

Y N Migraines/TMJ_____ _____

Y N HIV or AIDS _____If YES, what is your viral load? _____

Y N Herpes, chancre sores, cold sores, shingles _____

Y N ANY infections requiring hospitalization (explain) _____

Y N ANY abnormal lab test or X-ray (describe) _____

Y N EVER hospitalized and why _____

Y N DATE of last physical exam, by whom _____

If applicable

Y N Number of pregnancies/children and year of birth_____

_____ Vaginal _____ C-Section

Y N Breastfeeding :Bra Size: Pre-pregnancy _____ During Pregnancy ___ Current _____

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Y N Last Mammogram: Date: _____ Normal _____ Abnormal _____
Y N Desire to have larger/smaller/lifted breasts;**Current Bra Size:** _____ **Desired Bra Size:**_____
Y N Vaginal dryness or use of lubrication/creams _____
Y N Genital Looseness _____
Y N Urinary Leakage _____# per day _____
Y N History of endometriosis/vaginal surgeries/hysterectomy_____
Y N Last Pap Smear: Date: _____ Normal _____ Abnormal _____
Y N Is there a possibility you may be pregnant? DATE of last menstrual period _____

BLOOD CLOTTING INFORMATION

Y N History of DVT (deep venous clots), PE (pulmonary embolus), or phlebitis (vein infections)
Y N Difficulty blood clotting or easy bruising or easy bleeding _____
Y N Heavy, prolonged or excessive menstrual periods _____
Y N History of blood clotting problems, either TOO MUCH or TOO LITTLE clotting _____
Y N Are you pregnant, have had a baby, or an abortion in the past 3 months:_____
Y N Birth Control, Hormone, or Hormone Replacement:_____
Y N Do you have or have you ever had varicose veins:_____

SURGICAL HISTORY

Y N List all surgeries you have had _____
Y N Have you ever had LASIK or other eye surgery _____
Y N Difficulty ***or nausea*** with local or general anesthesia _____

FAMILY HISTORY

Y N Any cancer in your family? What kind and who? _____
Y N Do you have breast cancer in your family? If so, Who? _____
Y N Any bleeding or blood clots in your family? What kind and who? _____
Y N Any history of difficulty with general anesthesia in your family? What kind and who?
_____

PERSONAL HISTORY

Y N Smoking (ever) how much, when_____
Y N Recreational drugs _____
Y N Alcohol, how much _____
Y N Employed, by whom, what position _____
Y N Married _____
Y N If you undergo surgery, do you have a caretaker? _____

MEDICATIONS AND SUPPLEMENTS YOU ARE TAKING

Y N Prescription medications _____
Y N Vitamins _____
Y N Herbal supplements including herbal teas_____
Y N Non-prescription or over-the-counter medications _____
Y N Recreational drugs, steroids _____

PHARMACY : NAME & PHONE NUMBER: _____

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I WOULD LIKE TO DISCUSS:

Y N Breast _____

- ☐ Breast Enlargement (Current size_____)
- ☐ Breast Lift for Sagging breast
- ☐ Nipple Reduction
- ☐ Areola Reduction
- ☐ Inverted Nipple Repair
- ☐ Revision of previous breast surgery
- ☐ Removal and replacement of current implants
- ☐ Scar revision
- ☐ Bra fat rolls

Y N Tummy _____

- ☐ Loose skin
- ☐ Fat reduction
- ☐ Muscle spreading/hernia
- ☐ Belly Button revision
- ☐ Scar revision

Y N Genitalia_____

- ☐ Mons lift
- ☐ Excess skin
- ☐ Looseness
- ☐ Fat reduction
- ☐ Urinary incontinence
- ☐ Vaginal Dryness
- ☐ Decreased sensation

Y N Buttocks_____ _____

- ☐ Cellulite
- ☐ Skin looseness
- ☐ Buttock lift
- ☐ Buttock enlargement

Y N Arms/Legs/Knees/Ankles_____

- ☐ Fat Reduction
- ☐ Skin Tightening
- ☐ Wrinkled or sagging skin
- ☐ Thick ankles
- ☐ Small calves
- ☐ Spider veins

Y N Face_____

- ☐ Loose skin
- ☐ Double chin
- ☐ Jawline reduction/sculpting
- ☐ Cheek reduction/sculpting
- ☐ Facial Fillers/Rejuvenation
- ☐ Migraine Treatment
- ☐ TMJ treatment
- ☐ Sagging or bulging eyelids
- ☐ Lip enlargement/rejuvenation
- ☐ Prominent ears
- ☐ Enlarged or wrinkled earlobes
- ☐ Split earlobes or stretched earlobes
- ☐ Thin eyelashes
- ☐ Sunscreen
- ☐ Hyperpigmentation
- ☐ Wrinkles
- ☐ Low eyebrows

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