Revalla Plastic Surgery

Lisa M. Hunsicker, MD, FACS

7750 S. Broadway, #150 • Littleton, CO 80122-2634

Phone (720) 283-2500 • Fax (720) 283-1122

Name _____ **Date** _____
Last Name First Name Initial

PATIENT HEALTH INFORMATION

Birth Date _____ Age _____ Sex _____ Height _____ Weight _____

Marital Status _____ Occupation _____

Primary Care Physician _____ Phone _____

Address _____ City _____ State _____ Zip_____

Referring Physician (if applicable) _____ Phone _____

Address _____ City _____ State _____ Zip _____

Reason(s) for which you are seeking consultation (check all that apply)

Aesthetic/Cosmetic Surgery

□ Breast Enlargement
□ Breast Lift
□ Breast Revision
□ Breast Reduction
□ Abdominal (Tummy) Tuck
□ Eye/Brow Lifting
□ LipoSelection/Liposuction
□ Botox
□ Fillers (Juvederm)
□ Facial Rejuvenation
□ Vaginal Rejuvenation
□ Bioidentical Hormone Replacement
□ Other _____

Reconstructive Surgery

□ Breast Reconstruction
□ Skin Cancer/Lesion/Scar
□ Head/Face/Hand Injury
□ Burn Injury
□ ER Follow-up

Have you seen another doctor(s) for this reason? □ Yes □No
If yes, who have you seen_____ When_____?

Past Medical History - Have you been diagnosed with any of the following health problems? (check all that apply)

□ Eye Problems
□ Ear/Hearing Problems
□ Nose Problems/Sinusitis
□ Herpes/Cold Sores/ Fever Blisters
□ Migraines
□ Head Injury/Concussion
□ Stroke/Seizures
□ Anxiety/Depression
□ Mental Illness
□ Asthma/Lung Problems
□ Emphysema
□ Pneumonia
□ Tuberculosis (TB)
□ Persistent Cough
□ Heart Attack/Disease
□ Heart Murmur/Rheumatic Fever
□ Chest Pain
□ High Blood Pressure
□ High Cholesterol
□ Blood Clots/DVT
□ Bleeding Disorder
□ Diabetes/Low Blood Sugar
□ Thyroid Problems
□ Anemia
□ Liver Problems/Hepatitis/Jaundice
□ Abdominal/Digestive Problems
□ Ulcers/Reflux
□ Urinary Problems/Kidney Infections or Kidney Stones
□ Breast Masses
□ Heavy Scarring Problems
□ Broken/Cracked Bones
□ Dislocations
□ Arthritis/Joint Problems
□ Back Problems
□ Fibromyalgia
□ Lupus/Scleroderma
□ Autoimmune Disease
□ AIDS/HIV
□ Cancer, Type: _____
□ Taken Fen Phen

Health History - Complete the following

List the dates of your most recent:

Physical Exam _____ Normal? □Yes □No
Blood work/Labs _____ Normal? □Yes □No
EKG _____ Normal? □Yes □No
Chest x-ray _____ Normal? □Yes □No
Other: _____ Normal? □Yes □No

Do you regularly exercise? □Yes □No
If yes, what do you do? _____
_____
How often? _____
For how long? _____
Since when? _____

Name _____ **Date** _____
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Review of Systems- In each area, if you are experiencing any of the symptoms listed, **PLEASE CIRCLE THOSE THAT APPLY**, or explain any that may not be listed. If you are not having any difficulties, please check "No Problems." If you have any questions about this, please ask one of the staff or your doctor.

Constitution (Health in General) ❑No Problems. Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaw when eating, scalp tenderness, prior diagnosis of cancer.
Other: _____

Ears, Nose, Mouth & Throat ❑No Problems. Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness.
Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems. Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ❑ No Problems. Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray.
Other: _____

GI (Stomach & Intestines) ❑No Problems. Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ❑No Problems. Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other:_____

MS (Muscles, Bones, Joints) ❑No Problems. Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integ. (Skin, Hair & Breast) ❑No Problems. Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑No Problems. Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑No Problems. Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑No Problems. Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other:_____

Hematologic (Blood/Lymph) ❑No Problems. Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑No Problems. Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

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Past Surgical History - List all prior surgical procedures including minor, elective, and cosmetic surgery:

_____ _____
_____ _____

Anesthesia- If you have had surgery, check type(s) of anesthesia you received and circle any problem(s).
□ General Anesthesia Nausea / Vomiting / Slow Awakening / Difficult Intubation / Other _____
□ IV Sedation Nausea / Vomiting / Slow Awakening / Other _____
□ Epidural/Spinal Nausea / Vomiting / Insufficient / Bleeding / Headache / Other _____
□ Block Insufficient / Prolonged / Systemic Reaction / Other _____
□ Local Insufficient / Heart Palpitations / Systemic Reaction / Other _____

Allergies - (check all that apply):

□ Antibiotics	□ Aspirin	□ Cosmetics
□ Penicillin	□ Codeine	□ Latex
□ Mycins	□ Morphine	□ Other(s) _____
□ Sulfa	□ Adhesive	□ None

Current Medications - (check and add all that apply)

Prescription Medications	*Pain Relievers*	*Vitamins*	*Herbal Supplements*	
_____	□ Aspirin (Bayer,	□ Multi-vitamin	□ Diet Pills	□ Kava-kava
_____	Excedrin, etc)	□ Vitamin C	□ Echinacea	□ Licorice
_____	□ Ibuprofen (Advil,	□ Vitamin E	□ Ephedra	□ Metabo-Life
_____	Motrin, etc)	□ Other(s):	□ Feverfew	□ Saw Palmetto
_____	□ NSAIDS (Aleve, etc)	_____	□ Garlic	□ Soy
_____	□ Other(s):	_____	□ Ginseng	□ St. John's Wort
_____	_____	_____	□ Ginko	□ Valerian
_____	_____	_____	□ Goldenseal _____	

For Women Only - Complete the following

Age at 1st menstrual period_____
Age at 1st pregnancy_____
Number of pregnancies? _____
How many live births?_____
How many cesareans? _____
Number of miscarriages? _____
Have you breast fed? □ Yes □ No

Date of last menstrual cycle _____
Date of most recent Pap smear _____ Normal? □ Yes □ No
Date of most recent mammogram _____ Normal? □ Yes □ No
Birth Control Method:
□ Menopause □ Tubal Ligation
□ Hysterectomy □ Birth Control Pills
□ Other:_____

Past Hormone Replacement Therapy:_____
Current Hormone Replacement Therapy:_____

For Men Only - Have you had a vasectomy? □ Yes □ No

Social History - Complete the following
Do you smoke? □ Yes □ No If yes, _____ packs per day for _____ years
Have you ever smoked? □ Yes □ No If yes, when did you quit? _____ and
How much did you smoke? _____ packs per day for _____ years
Do you use recreational drugs? □ Yes □ No If yes, please list _____
Do you drink alcohol? □ Yes □ No If yes, _____drinks per day/week
Are you sexually active? □ Yes □ No If not, is there pain or physical reasons? □ Yes □ No
Are you able to have an orgasm? □ Yes □ No

Family History - (check all that apply)

□ Blood Clots	□ Diabetes	□ Breast Cancer
□ Bleeding Disorder	□ Reflux Disease	Who? _____
□ Stroke	□ Ulcers	□ Other Cancers
□ Asthma	□ Thyroid Problems	What? _____
□ Heart Disease	□ Arthritis/Joint Pain	□ Other _____
□ High Blood Pressure	□ AIDS/HIV	□ Alzheimer's Disease
□ Osteoporosis		

_____ Date _____
Signature of Patient

_____ Date _____
Signature of Physician
Lisa M. Hunsicker, MD, FACS

Updated 8/21/15