# RUCKER MD
PLASTIC SURGERY CLINIC

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# Health Questionnaire

**NAME:** FIRST MIDDLE LAST

DATE OF BIRTH

TODAY'S DATE

| **PERSONAL HISTORY:** | **YES** | **NO** | **REMARKS** |
|---|---|---|---|
| TB (TUBERCULOSIS) | ☐ | ☐ | |
| DIABETES | ☐ | ☐ | |
| HEART TROUBLE | ☐ | ☐ | |
| BLOOD PRESSURE | ☐ HIGH | ☐ LOW | ☐ NORMAL |
| STROKE | ☐ | ☐ | |
| ANEMIA | ☐ | ☐ | |
| CANCER | ☐ | ☐ | |
| EPILEPSY | ☐ | ☐ | |
| NERVOUS DISORDER | ☐ | ☐ | |
| ASTHMA | ☐ | ☐ | |
| HAY FEVER | ☐ | ☐ | |
| INFECTIONS | ☐ | ☐ | |
| BLEEDING HISTORY | ☐ | ☐ | |
| HEPATITIS | ☐ | ☐ | |
| SINUSITIS | ☐ | ☐ | |

OTHER DISEASES

| **ALLERGIES & SENSITIVITIES** | **YES** | **NO** | **REMARKS** |
|---|---|---|---|
| DEMEROL | ☐ | ☐ | |
| PENICILLIN | ☐ | ☐ | |
| SULFA DRUGS | ☐ | ☐ | |
| OTHER ANTIBIOTICS | ☐ | ☐ | |
| ASPIRIN | ☐ | ☐ | |
| CODEINE | ☐ | ☐ | |
| MORPHINE | ☐ | ☐ | |
| ANESTHETICS | ☐ | ☐ | |
| ADHESIVE TAPES | ☐ | ☐ | |

FOODS

PREVIOUS SURGERIES AND DATES:

HAVE YOU HAD ANY COSMETIC SURGERY? ☐ YES ☐ NO

IF YES, PLEASE SPECIFY

NO OF PREGNANCIES

NO OF CHILDREN

LAST MENSTRUAL PERIOD

CURRENT MEDICATION AND VITAMINS

LAST PHYSICAL CHECKUP

GENERAL HEALTH

DO YOU SMOKE? ☐ YES ☐ NO IF YES, HOW MUCH ?

CONSUME ALCOHOL : ☐ YES ☐ NO HOW MUCH ?

HAVE YOU EVER CONSULTED A PSYCHIATRIST? ☐ YES ☐ NO

ARE YOU CURRENTLY SEEING A PSYCHIATRIST? ☐ YES ☐ NO

IF YES, PSYCHIATRIST'S NAME & ADDRESS

PHONE