Stonegate
PLASTIC SURGERY
OF LAKELAND

Patient Questionnaire

Please fill out this questionnaire carefully so that we have all of the medical information to prepare you for your surgery. If you complete this questionnaire at home, fax form to (269) 556-6020 or email to info@stonegateplasticsurgery.com

Patients Name:*(Please Print)*______________________________ Date:______________

Cell #: ____________ Home/Work #:__________ Email:______________________________

Date of Birth:____________ Height:__________ ❑inch/❑cm Weight:____________ ❑lbs/❑kg

Emergency Contact:________________________ Relationship to Emergency Contact:________________

Emergency Contact Cell #__________ Occupants living with you, and their relationship to you:____________

Occupation:________________________ **Which hand do you write with? ❑Left ❑Right ❑Both**

Employer:________________________ **Hobbies:**________________________

Who referred you:________________________ **Reason for todays visit:**________________________

List all people who live with you and their relationship:____

____

Do you have or have you ever had any of the following:

If YES please check the box and list the date:

❑HgA1C lab test(result & date):______________ ❑Heart echo(ultrasound) test-date:______________

❑Blood Glucose test(result & date)______________ ❑Holter rhythm test-date:______________

❑Heart catheterization(angiogram)-date:__________ ❑Pulmonary function test-date:______________

❑EKG-date:______________ ❑Other-specify test & date:______________________________

Please list all your primary care and specialist providers name and contact information

❑Primary Medicine:________________________________ Phone:______________

Last time seen by Primary care physician:________________________________

❑Heart Specialist(Cardiologist):________________________________ Phone:______________

❑Lung Specialist(Pulmonologist):________________________________ Phone:______________

❑Other(specify):________________________________ Phone:______________

Do you smoke tobacco? ❑Yes ❑No If yes, how many packs in a day?_____ Length of time smoking:_______

Are you a former smoker? ❑Yes ❑No If yes, when did you quit?_______ How long did you smoke?_________

Do you have a history of blood clots? ❑Yes ❑No

If yes, please list occurrences:________________________

Does anyone in your family have a history of blood clots? ❑Yes ❑No

If yes, list who:________________________

Do you have any allergies?(for example drugs, food, latex, etc.) ❑Yes ❑No

If yes, please specify:________________________

Do you have a history of easy bleeding after surgery? ❑Yes ❑No

Do you take any blood thinners? ❑Yes ❑No

If yes, please list________________________

Do you currently take pain medication? ❑Yes ❑No

If yes, please list:________________________

Do you or have any of your close family had serious problems with anesthesia? ❑Yes ❑No

If yes, please describe:________________________

Do you currently have a pain contract? ❑Yes ❑No

What pain medications have worked best for you in the past? ________________________

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List all previous surgeries: ❑ None

____
____
____
____

List all(any) complications:

____
____
____
____

Do you have or have you ever had any of the following: *if yes please check box*

❑Chest pain, heat attack or other heart problems	❑Shortness of breath walking and/or climbing stairs	❑Heart irregularities or palpitations	❑Heartburn or hiatus hernia or acid reflux
❑High blood pressure	❑Unexplained weight loss(10-12 pounds in 6 months)	❑Stomach Ulcers	❑Heart surgery or angioplasty
❑Heart pacemaker: Type_______________ Model__________	❑Skin Sore/Open Wound Location:_________________	❑Asthma or wheezing	❑Home Oxygen
❑Back trouble, fractures, or herniated disc	❑Chronic Cough	❑Lung Problem or abnormal chest x-ray	❑Diabetes-accucheck range:_________ A1C______________
❑Seizures or epilepsy	❑Kidney/bladder/urination problems	❑Liver problems	❑Hepatitis or positive HIV test
❑Stroke or intermittent numbness or blackouts	❑Abnormal ECG	❑Sleep Apnea	❑Thyroid problems
❑Rheumatoid Arthritis/autoimmune disorder	❑Frequent fainting or dizziness	❑Prior bleeding or clotting disorders	❑Recreational drugs? If so, which:___________________
❑Do you drink alcohol? If so how many drinks a week?_______	❑Severe snoring, or sleep apnea(stopping breathing while asleep)	❑History of miscarriage	❑Chronic pain
❑Do you have a history of substance abuse? How long in recovery?______________________	❑Do you have difficulities opening your mouth or moving your neck?	❑Do you have problems swallowing?	

Do you take any medication? ❑Yes ❑No If yes, please list the name, dosage, and how many times taken per day of each:

Name of Medication	Dosage	#times per day	Name of Medication	Dosage	#times per day

For women only: Date of last mammogram:_____________ Result:___________________

Date of last menstruation(period):_______________ Do you currently take birth control? ❑Yes ❑No

Will you accept a blood transfusion if needed? ❑Yes ❑No

Do you have any serious illnesses that we have not mentioned? If yes, please list: ❑Yes ❑No

____

I attest the above information is correct to the best of my knowledge.

Signature:____ Print Name:______________________________________ Date:____________

Form Completed by: ❑Patient ❑Relative(specify relationship to patient:___________________________________)