Metamorphosis Plastic Surgery, L.L.C.
Daniel P. Markmann, M.D.

MEDICAL HISTORY QUESTIONNAIRE
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Date _____

Patient's Name _____ Age _____ Height _____ Weight _____

Present general health: (Circle One) Excellent Good Fair Poor
Reason for appointment: _____

Medical History (Check each that applies to you **AND** place an "F" if it applies to family member)

____ ABDOMINAL PAIN – *CHRONIC*
____ ALLERGIES/HAYFEVER
____ ANEMIA ____ BRUISE EASILY
____ ANKLES – *SWOLLEN*
____ APPETITE – *LOSS OF*
____ ARTHRITIS/RHEUMATISM
____ ASTHMA/WHEEZING
____ BACK PAIN – *RECURRENT*
____ BONE FRACTURE/JOINT INJURY
____ BOWEL HABITS –*CHANGE IN*
____ BRONCHITIS/CHRONIC COUGH
____ CANCER
____ CHEST PAIN
____ CONVULSIONS/SEIZURES
____ DIABETES
____ DIARRHEA CONSTIPATION
____ DIPHTHERIA
____ DIVERTICULOSIS ____ COLITIS
____ DIZZINESS/FAINTING
____ EAR INFECTIONS –*FREQUENT*
____ EAR – *RINGING IN*
____ EYE INFECTIONS
____ FATIGUE – *CHRONIC*
____ FOOT PAIN ____ COLD NUMB FEET
____ GALL BLADDER TROUBLE
____ GOUT
____ HAIR LOSS
____ HEADACHES – *FREQUENT*
____ HEART MURMUR
____ HEMORRHOIDS
____ HERNIA
____ HIGH BLOOD PRESSURE
____ INDIGESTION OR HEARTBURN
____ INFECTIONS – *FREQUENT*
____ JAUNDICE/HEPATITIS
____ KIDNEY STONES
____ LACTOSE INTOLERANCE
____ LEG PAIN – *WALKING*
____ MEMORY LOSS
____ MENTAL ILLNESS
____ MOODINESS –*EXCESSIVE*
____ MUSCLE WEAKNESS
____ NAUSEA/VOMITING –*PERSISTENT*
____ NERVOUSNESS ____ DEPRESSION
____ NOSE BLEEDS
____ NUMBNESS/TINGLING SENSATIONS
____ OSTEOPOROSIS
____ PHOBIAS
____ PNEUMONIA
____ PROSTATE DISEASE
____ PSORIASIS ____ ECZEMA
____ RASHES ____ HIVES
____ SEXUAL/MENSTRUAL DYSFUNCTION
____ SINUS TROUBLE
____ STOOLS – *BLOODY OR TARRY*
____ STROKE
____ SWALLOWING DIFFICULTY
____ TETANUS
____ THROAT – SORE –*FREQUENT*
____ THYROID DISEASE
____ TREMOR/HANDS SHAKING
____ ULCERS – *PEPTIC*
____ URETHRAL DISCHARGE
____ URINATION- ____ OVERNIGHT 2X+
____ DECREASE IN FORCE/FLOW
____ PAINFUL ____ LOSS OF CONTROL
____ URINE – *BLOOD IN*
____ VARICOSE VEINS/PHLEBITIS
____ VENEREAL DISEASE
____ VISION – *FAILING*
____ WEIGHT LOSS – *RECENT*
____ **OTHER** – *DESCRIBE BELOW*

_____

Prescribed Medications with dosage

_____

_____

Over-the-counter medications or illicit drugs_____

Medication Allergies or Other Allergies:_____

_____

_____

Patient's Name_____ **Date** _____

MEDICAL HISTORY QUESTIONNAIRE
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Prior surgeries with year performed:

_____

_____

_____

_____

Tobacco? Yes _____ No _____ # of Packs per day _____
Alcohol? Yes _____ No _____ # of Drinks per day _____ or per week _____

When was your last tetanus shot? _____

Have you ever had problems with anesthesia? Yes _____ No _____

Explain_____

Family physician's
name_____

Address_____City_____ST_____ZIP_____
_

Phone _____

WOMEN ONLY

GYN's name
_____

Address_____City_____ST_____ZIP_____
_

Phone _____

		C-Section	Vaginal
Do you have children? _____ If so, how many? _____	Age _____	_____	_____
	Age _____	_____	_____
	Age _____	_____	_____