Richard D. Zeph, M.D.
Facial Plastic and Reconstructive Surgery
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MEDICAL QUESTIONNAIRE AGES 0 TO 18 YEARS

Name: _____ Birthdate: _____Date:_____

Address: _____

Parent's Names:_____

Parent's Cell: (____)_____Parent's Cell: (_____)_____

School: _____ Grade: _____

Email address_____

(**REQUIRED) Pharmacy Name**_____

Address_____**Phone (_____)**_____

How were you referred to us? _____

What are you being seen for today:_____
Have you consulted any other physicians about this? _____
Name, address and phone of your family physician:_____

_____

Have you discussed this with your family doctor? _____

Have you ever been hospitalized of any reason, including medical illness? _____

_____

Have you ever had any surgery of any kind including tonsils, adenoids? _____

_____

Were there any complications? _____
Do you or any family members have any history of medical problems?_____

_____

Have you ever had any stitches before? _____
When was your last physical examination? _____
What is your height?_____**Weight?**_____
NO YES Are you allergic to any medications (list)? _____
NO YES Are you currently taking any medications (list)?_____

(OVER)

NO YES Have you ever received local anesthesia (Novocaine or Xylocaine) from a doctor or dentist? _____

NO YES Have you ever had a reaction? _____

NO YES Do you take vitamins regularly? _____

NO YES Do you have hay fever, nasal allergies, or asthma? _____

NO YES Do you have a history of bleeding? _____

NO YES Do you have any bleeding tendencies or easily bruise? _____

NO YES Do you have any problems with your eyes? _____

NO YES Do you have any stomach troubles or ulcers? _____

NO YES Do you have any chest or lung problems? _____

NO YES Have you been told you had any heart trouble or heart murmurs? _____

_____

NO YES Have you ever had any liver problems such as hepatitis or yellow jaundice? _____

_____

NO YES Do you have frequent skin infections, skin rashes, or irritations? _____

_____

NO YES Have you ever had a convulsion or seizure? _____

NO YES Has any part of your body ever been paralyzed or numb? _____

_____

NO YES Are you frequently ill? _____

NO YES Have you ever been treated for anemia or other problems with your blood? _____

_____

NO YES Have you ever consulted or considered consulting a psychiatrist or psychologist?

_____

NO YES Do you have any other medical problems that have not been covered? _____

_____

NO YES Are your immunizations up to date including tetanus toxoid? _____

NO YES Do you smoke? How many cigarettes per day? _____

IF APPLICABLE:

When was your last menstrual period? _____

NO YES Are your periods often irregular?

NO YES If applicable, is there a possibility of pregnancy at this time?

NO YES Have you had “female” or GYN problems? _____

Signature: _____ Date: _____

Relationship to patient: _____