BARBOUR
PLASTIC SURGERY

Name: _____ **Today's Date:** _____

Referred by: _____ **Date of Injury/Onset of Symptoms:** _____

Reason for Visit (please briefly describe injury or onset of issue):

_____

_____

Pain Quality: Sharp Dull Stabbing Burning Zinging/Nerve Pains Constant Intermittent

Other: _____

Pain Intensity (please indicate):

0 (No Pain)
1-3 (Mild Pain – Noticeable but tolerable, can perform all daily activities)
4-6 (Moderate Pain – Pain makes daily activities difficult, distracting but can perform some daily activities)
7-9 (Severe Pain – Cannot perform daily activities, trouble sleeping and speaking normally)
10 (Worst Pain Imaginable – Cannot get out of bed, need to be taken to emergency room)

What makes your pain better? Rest Activity Modification Ice/Heat Medication Other: _____

What treatments have you attempted? PT Medications Injections Surgery Other: _____

Past Medical and Family History (check all that apply – please indicate if self or family member):

	Self	Family		Self	Family		Self	Family		Self	Family
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Stroke	☐	☐	Diabetes	☐	☐
COPD	☐	☐	Asthma	☐	☐	Reflux	☐	☐	Ulcers	☐	☐
Kidney Disease	☐	☐	Vascular Disease	☐	☐	Hepatitis	☐	☐	Blood Clots	☐	☐
Bleeding Disorder	☐	☐	Cancer	☐	☐	Arthritis	☐	☐	Seizures	☐	☐
Headaches	☐	☐	HIV	☐	☐	Other: _____					

Past Surgical History:

Appendectomy	☐	Gall Bladder	☐	Hernia	☐	Breast	☐
Heart Bypass	☐	Heart Valve	☐	Pacemaker	☐	Spine/Neck	☐
Arthroscopy	☐	Joint Replacement	☐	Rotator Cuff	☐	Hysterectomy	☐

Other: _____

Medications (list all prescription and over the counter medications/supplements or indicate separate list attached):

_____

_____

_____

_____

Drug Allergies (list all known drug allergies):

_____

_____

_____

_____

Social History: Single Married Divorced Widowed Children? NO YES #_____

Smoking: Former Smoker (as of _____ date) Never Smoker Current Smoker (____Packs/day)

Do you drink alcohol? No Yes _____drinks/week

What is your occupation? _____

Do you exercise regularly? Never Once a day A few times a week A few times a month

Review of Systems:

Do you currently or frequently have (check all that apply):

Hematologic/Lymphatic

- □ Problems with bleeding

Integumentary

- □ Problems with healing
- □ Problems with scarring (hypertrophic or keloid)
- □ Rash

Cardiovascular

- □ Chest Pain
- □ Palpitations
- □ Leg Pain with Walking

Constitutional/Symptom

- □ Fever or Chills
- □ Night Sweats
- □ Unintentional Weight Loss

Endocrine

- □ Thyroid Problems

ENT and Mouth

- □ Sore Throat

Eyes

- □ Blurry Vision

Gastrointestinal (G.I.)

- □ Abdominal Pain
- □ Bloody Stool
- □ Nausea/Vomiting
- □ Constipation
- □ Diarrhea
- □ Difficulty Swallowing
- □ Bloody Urine

Musculoskeletal

- □ Joint Aches
- □ Muscle Weakness
- □ Neck Stiffness

Neurological

- □ Headaches
- □ Seizures
- □ Facial Weakness

Respiratory

- □ Cough
- □ Shortness of Breath
- □ Wheezing
- □ Bloody Sputum
- □ Problems with Snoring

Psychiatric

- □ Anxiety
- □ Depression

Miscellaneous

- □ Allergic to adhesive
- □ Allergic to lidocaine
- □ Allergic to topical antibiotic ointments
- □ Artificial heart valve
- □ Artificial joints w/in the past 2 years
- □ Blood thinners
- □ Defibrillator
- □ MRSA
- □ Pacemaker
- □ Other: _____