Jeffrey J. Roth, M.D., F.A.C.S.
Board Certified
American Board of Surgery
American Board of Plastic Surgery
plastic surgery

PATIENT HEALTH HISTORY

Patient Name: _____ **DOB**: _____ **Age**: _____

Height: _____ **Weight**: _____ **Primary Care Doctor:** _____

Current Medical Problems / Illnesses:

_____

List Previous Surgeries (including cosmetic surgery):

_____

_____

_____

List All Medications including vitamins, supplements, herbal medicines:

_____

_____

List any Medication Allergies, Food & Environmental Allergies:

_____

_____

Past Medical History:

Heart Disease	☐ Yes ☐ No	HIV or AIDS	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Lung Disease	☐ Yes ☐ No	Joint Replacement	☐ Yes ☐ No	Bleeding Tendency	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Skin Cancer	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Stomach Problems	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Breast Cancer	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Skin Cancer	☐ Yes ☐ No
Kidney Diease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
Blood Clot in Legs	☐ Yes ☐ No	Other Cancer	☐ Yes ☐ No	If so, what kind?	

Family History:

Have any of your relatives had any of the following? (Please check the appropriate answer)

Breast Cancer	☐ Yes ☐ No	If yes, relationship: _____
Skin Cancer	☐ Yes ☐ No	If yes, relationship: _____

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Diabetes	☐ Yes ☐ No	If yes, relationship: _____
Heart Disease	☐ Yes ☐ No	If yes, relationship: _____
Kidney Disease	☐ Yes ☐ No	If yes, relationship: _____
Stroke	☐ Yes ☐ No	If yes, relationship: _____
Depression	☐ Yes ☐ No	If yes, relationship: _____
High Blood Pressure	☐ Yes ☐ No	If yes, relationship: _____

Any issues with Anesthesia in the past? ☐ Yes ☐ No

If so, please describe: _____

Social History:

Do you currently smoke cigarettes? ☐ Yes ☐ No If so, how many packs per day? _____

Did you smoke before? ☐ Yes ☐ No If so, when did you quit? _____

Do you currently smoke marijuana? ☐ Yes ☐ No If so, how often? _____

Alcohol use? ☐ Yes ☐ No How many alcoholic drinks per week? _____

Recreational Drug Use? ☐ Yes ☐ No If so, what kind? _____

Review of Systems:

Have you had any of the below listed symptoms in the past year?

Fever & Chills	☐ Yes ☐ No	Swollen Feet	☐ Yes ☐ No	Swollen Lymph Nodes	☐ Yes ☐ No		
Skin Lesions/Rash	☐ Yes ☐ No	Body Piercing	☐ Yes ☐ No	Joint Pain	☐ Yes ☐ No		
Headache	☐ Yes ☐ No	Weight Change	☐ Yes ☐ No	Muscle Pain	☐ Yes ☐ No		
Dry Eyes	☐ Yes ☐ No	Abdominal Pain	☐ Yes ☐ No	Dentures	☐ Yes ☐ No		
Ear Infection	☐ Yes ☐ No	Chronic Cough	☐ Yes ☐ No	Wear Contacts	☐ Yes ☐ No		
Sinusitis	☐ Yes ☐ No	Chest Pain	☐ Yes ☐ No	Easy Bruising	☐ Yes ☐ No		
Wheezing	☐ Yes ☐ No	Sore Throat	☐ Yes ☐ No	Easy Bleeding	☐ Yes ☐ No		
Urinary Infection	☐ Yes ☐ No	Taken Steroids	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No		
Depression	☐ Yes ☐ No	Seizures	☐ Yes ☐ No	Tattoos	☐ Yes ☐ No		
Jaundice	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No	Breast Lump	☐ Yes ☐ No		

Women Only:

Number of pregnancies: _____ Date of last menstrual period: _____

Number of children: _____ Date of last mammogram? _____ Results: _____

Did you breast feed? ☐ Yes ☐ No

Do you perform regular self-examinations on your breasts? ☐ Yes ☐ No

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PATIENT REGISTRATION

Patient Name: _____ DOB: _____ Sex: ☐ Female ☐ Male

Street Address: _____ City:_____ State: ____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Occupation: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

Reason for today's visit: _____

How did you hear about us? Please choose all that apply. **Thank you!**

☐ I am a returning patient

☐ Referred by another patient Name: _____

☐ Referred by a doctor or medical professional Name: _____

☐ Referred by friend/family (not a patient) Name: _____

☐ Dr. Roth's Website ☐ Instagram ☐ Facebook ☐ American Society of Plastic Surgeons (ASPS)

☐ Dr. Roth's Podcast ☐ Word of Mouth ☐ Google ☐ Other _____

By signing below:

I consent for treatment / examination by Dr. Roth and/or his staff.

I consent to contact by phone, text and/or email for appointment reminders and/or marketing & practice news.

Signature:_____ Date: _____