

**University Plastic Surgeons**



**Center for Advanced Healthcare  
Division of Plastic Surgery  
2 Tampa General Circle  
Tampa, FL 33606**

**813-259-0929**

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**New Patient Questionnaire**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

**Present Illness:**

Why are you seeing the Doctor today and how long have you had these symptoms:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## MEDICAL HISTORY AND REVIEW OF SYSTEMS:

List all medications you are currently taking: \_\_\_\_\_

Do you take aspirin or products containing aspirin  Yes  No

List all hospitalizations, operations and serious injuries:

YEAR	HOSPITALIZATIONS - OPERATIONS – INJURY	HOSPITAL AND LOCATION
_____	_____	_____
_____	_____	_____
_____	_____	_____

### ILLNESS AND MEDICAL PROBLEMS

Dizzy Spells	Yes	No	Bleed Easily	Yes	No
Glaucoma	Yes	No	Bruise Easily	Yes	No
Other Eye Problems	Yes	No	Bleeding Disorder	Yes	No
Ear Trouble	Yes	No	Anemia	Yes	No
Sinus Trouble	Yes	No	Heart Attack	Yes	No
Deafness or decreased hearing	Yes	No	Heart Murmur	Yes	No
Repeated Nose Bleeds	Yes	No	Ankles Swell	Yes	No
Chronic Nose Obstruction	Yes	No	Other Heart Condition	Yes	No
Swelling in Neck	Yes	No	Stomach/Duodenal Ulcer	Yes	No
Asthma	Yes	No	Colitis	Yes	No
Bronchitis	Yes	No	Diverticulosis	Yes	No
Emphysema	Yes	No	Other Bowel Problems	Yes	No
Pneumonia	Yes	No	Hepatitis	Yes	No
Tuberculosis	Yes	No	Mononucleosis	Yes	No
Other Lung Problems	Yes	No	Gall Bladder Problems	Yes	No
Low Blood Pressure	Yes	No	Stroke	Yes	No
High Blood Pressure	Yes	No	Convulsion / Seizures	Yes	No
Scarlet Fever	Yes	No	Arthritis	Yes	No
Trouble with Anesthesia	Yes	No	Cancer Yr.	Yes	No
Diabetes	Yes	No	Have you ever received a blood transfusion?	Yes	No
Other			Have you ever received blood products?	Yes	No
Other				Yes	No

### WOMEN ONLY

Tender Breasts	Yes	No	Discharge from Nipples	Yes	No
Lumps or recent change in size	Yes	No	Fibrocystic Disease	Yes	No
Menstrual Problems	Yes	No	Previous Mammogram Year: _____	Yes	No
Birth Control Pills	Yes	No	Were your children breast fed?	Yes	No
Number of Pregnancies	# ____		Do you have breast implants?	Yes	No
Number of Live Births	# ____		Other implants?	Yes	No

### FAMILY HISTORY

Tuberculosis	Yes	No	Diabetes	Yes	No
Asthma	Yes	No	Rheumatoid Arthritis	Yes	No
Glaucoma	Yes	No	Heart Disease	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No
Relation:	Type of Cancer		Low Blood Pressure	Yes	No
Relation:	Type of Cancer		Blood Disorders (i.e. Sickle Cell Anemia, etc.)	Yes	No
Other :	Yes	No	Bleeding Tendency	Yes	No

### ALLERGIES

Penicillin	Yes	No	Effect
Novocaine/Xylocaine	Yes	No	Effect
Other Medicine:			Effect

### FAMILY DOCTOR

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

### AGENCY REPRESENTATIVE: (i.e., Workman's Comp):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**REFERRAL FROM:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Consent for Photograph**

I, do hereby authorize the taking of pictures, motion pictures, and/or television pictures of

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and consent to the use of any or all such pictures for teaching, lecturing and in publication media.

This consent is expressly intended to release liability, all personnel of the University of South Florida College of Medicine, Medical Clinics, Physicians, Photographer, and/or personnel of the publication media and the publication media.

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*Witness*

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*Signature of Person Granting Consent*

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*Witness*

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*Date*