

Cynthia M. Goodman, M.D.

Plastic & Reconstructive Surgery
History Intake Form

Patient Name: _____ Date: _____

Birth Date: _____

REVIEW OF SYSTEMS
Do you currently have any of the following problems?

If YES, Please explain

1. Constitutional (fever, weight loss, other)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Eyes (glaucoma, cataract, lazy eye, retina problems, other – please specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Ear / Nose / Mouth / Throat (hearing loss, sinus problems, sore throat)	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Cardiovascular (heart problems, chest pain, irregular heart beat)	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Respiratory (asthma, shortness of breath, wheezing, coughing)	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Genitourinary (urinary problems, blood in urine)	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Integumentary (skin rashes, excessive dryness)	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Musculoskeletal (muscle aches, joint pain, swollen joints)	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Neurological (numbness, weakness, headaches, paralysis)	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Hematologic/Lymphatic (blood disorders, leukemia)	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Allergic/immunologic (hay fever, allergies)	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Endocrine (thyroid problems)	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Psychiatric (depression, anxiety)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional Comments:

I verify that the above information is true and correct to the best of my knowledge.

Patient's Signature: _____ **Date:** _____

The above information has been reviewed with the patient.

Physician's Signature: _____ **Date:** _____