Wagner & Associates
Plastic & Reconstructive Surgery Consultants of Indiana
Initial Patient Evaluation

____
Date of Visit

Name__________________________ Age_______ Height_______ Weight________

Referring M.D.____

1. Reason for Consultation:
____

2. Cosmetic ☐
   Accident-Related ☐
   Worker's Comp. ☐
   Other ☐

3. Goals of Treatment/ Desired Outcomes:
____
____
____

4. Approximate date of onset:____

5. Symptoms (pain, infection, non-healing, etc.)
____
____

6. List prior treatments you have had or tried for this condition:

   Surgery (dates):
   ____
   ____

   Medications (dose & frequency):
   ____
   ____

   Physical therapy/ Occupational therapy (dates):
   ____
   ____

   Other:____
   ____

7. List X-rays, scans, or other diagnostic tests you have had for this condition (dates):____
   ____

8. Do you have any of the following diseases or conditions?
(Check all that apply)

□**High Blood Pressure**	□**Diabetes**	□**Problems with Anesthesia**
□**Heart Attack**	□**Seizures**	□**Swelling/Lymphedema**
□**Arrhythmia**	□**Angina/Chest Pain**	□**Rheumatic Fever**
□**Emphysema**	□**Bleeding with Surgery**	□**Pneumonia**
□**Thyroid Problems**	□**Hepatitis**	□**HIV Positive**
□**Blood Clot/DVT**	□**Asthma**	□**Cancer Type_______ Year____**

Previous Surgeries: Type____________________ Date________________________

Type____________________ Date________________________

Type____________________ Date________________________

Current Medication and dosage:

Drug Allergies:

Do you smoke? No□ Yes□ How many packs/day?____Years?__________

Do you drink alcoholic beverages? No□ Yes□ How many/week?______________

Marital Status__________ Occupation_______________# Children_________________

Family History

□High Blood Pressure	□Diabetes	□Anesthesia Reactions
□Heart Disease	□Vascular Disease	□Lung Disease
□Stroke	□Cancer	□Kidney Disease

□Melanoma: Relationship____________________________________

Review of Systems

CNS	Yes	No
1. H/A	☐	☐
2. Weakness/Numbness	☐	☐
3. Blurred Vision	☐	☐
4. Paralysis	☐	☐
5. Sroke/TIA	☐	☐

Respiratory	Yes	No
1. SOB at Rest	☐	☐
2. SOB w/exertion	☐	☐
3. Excess/Bloody sputum	☐	☐
4. Cough	☐	☐
5. H/O Lung Surgery	☐	☐
6. H/O Pulm. Embolus	☐	☐
7. Use Home Oxygen	☐	☐

Cardiovascular		
1. Chest Pain	☐	☐
2. Shortness of Breath	☐	☐
3. Leg Swelling	☐	☐
4. Irregular heart beat	☐	☐
5. Cardiac Surgery/Bypass	☐	☐
6. Use of Blood Thinner	☐	☐
7. Valvular Disease/Replacement	☐	☐

Gastrointestinal		
1. Nausea/Vomiting	☐	☐
2. Constipation	☐	☐
3. Diarrhea	☐	☐
4. Abdominal pain	☐	☐
5. Bleeding/black stool	☐	☐
6. H/O Ulcer	☐	☐
7. Diverticulosis	☐	☐
8. GERD/Reflux	☐	☐

GU		
1. Pain upon urination	☐	☐
2. Bloody urine	☐	☐
3. Urinary Infection	☐	☐
4. Abnormal bleeding Between periods	☐	☐
5. Kidney stones	☐	☐
6. Kidney Failure/Dialysis	☐	☐

Musculoskeletal		
1. Muscle Pain	☐	☐
2. Joint Pain	☐	☐
3. Artificial Joints	☐	☐
4. H/O Fractures	☐	☐
5. Arthritis	☐	☐

Skin		
1. New Nodules	☐	☐
3. Skin conditions	☐	☐
4. Other Skin Cancers	☐	☐
5.Eczema	☐	☐

General		
1. Fever	☐	☐
2. Weight Loss	☐	☐
3. Night Sweats	☐	☐
4. Loss of appetite	☐	☐

Lymphatic/Cancer			
1. Other Cancers	☐	☐	Type:______________________________
2. Enlarged Lymph Nodes	☐	☐	
3. Blood Disorders	☐	☐	
4. Currently w/disease	☐	☐	