Radiance
CENTER FOR FACIAL REJUVENATION

HPI SHEET

Name _____ Birth Date _____ Date _____

Chief complaint or illness:

1. What is the reason for today's visit? _____.
2. How long have you had this problem? _____.
3. How severe is this problem? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

   MILD VERY SEVERE
4. Have you had your hearing tested in the last year? ☐ Yes ☐ No Is it ever difficult to understand speech? ☐ Yes ☐ No
5. Have you had more than one sinus infection in the last year? ☐ Yes ☐ No Do you ever experience sinus pressure? ☐ Yes ☐ No
6. Do you have any hoarseness or changes in your voice? ☐ Yes ☐ No Do you have soreness or difficulty swallowing? ☐ Yes ☐ No
7. Do you suffer from allergies such as ☐ hay fever, ☐ asthma, ☐ eczema, or ☐ food allergies? (check appropriate items)
   If yes, describe: _____.

Have **you** or a **family member** ever had the following?

	You	Mother	Father	Brother(s)	Sister(s)
Anesthesia Reactions	☐	☐	☐	☐	☐
Blood Clots – DVT/PE	☐	☐	☐	☐	☐
Bleeding Tendency	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐

Are any of your family members **deceased?** ☐ Yes ☐ No

If you answered yes, which family member(s) is **deceased?** ☐ Mother ☐ Father ☐ Brother(s) ☐ Sister(s)

Please list any other chronic illnesses or diseases you have: _____

_____.

List all previous surgeries Month/Year ☐ See Attached List

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Drug allergies

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____

Medications (List all current medications, the dose you take, and how often.) ☐ See Attached List

1. _____ Dose _____
2. _____ Dose _____
3. _____ Dose _____
4. _____ Dose _____
5. _____ Dose _____
6. _____ Dose _____
7. _____ Dose _____
8. _____ Dose _____
9. _____ Dose _____
10. _____ Dose _____

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Social history

Occupation _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

How many children do you have? _____ If a child, do you live at home with ☐ Both Parents ☐ Mother ☐ Father

Do you smoke or use tobacco? ☐ YES ☐ NO (☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing Tobacco ☐ Vapor)

If yes, How much? (Packs per day) _____ for _____ years.

Did you quit smoking? ☐ YES ☐ NO If yes, when? _____

Do you use alcohol? ☐ YES ☐ NO How much and how frequently? _____

List any street drugs you have used: _____

Do you have any drug or alcohol addictions? ☐ YES ☐ NO

Do you have any reason to believe you are at risk for HIV, AIDS, or HEPATITIS? ☐ YES ☐ NO

REVIEW OF SYSTEMS:

(Please check any of the following that you are **CURRENTLY EXPERIENCING** or **BEING TREATED FOR**)

Constitutional

☐ Recent weight change ☐ Fever/chills ☐ Fatigue

Eyes:

☐ Double vision
☐ Loss of vision
☐ Eye pain
☐ Eye disease or injury
☐ Wear contacts or glasses

ENT:

☐ Hearing loss
☐ Ringing in ears
☐ Dizziness
☐ Ear pain
☐ Ear drainage
☐ Nose drainage
☐ Nasal congestion
☐ Facial pain
☐ Headaches
☐ Sore mouth/throat
☐ Swallowing pain
☐ Voice change
☐ Snoring
☐ Hoarseness
☐ Poor sleep

Cardiovascular/Pulmonary

☐ Chest pain
☐ Heart attack
☐ Irregular heartbeat
☐ Feeling faint/lightheaded
☐ Poor circulation
☐ Leg pain during walking
☐ Coughing up blood
☐ Shortness of breath
☐ Wheezing
☐ Unusual shortness of breath while climbing stairs

Gastrointestinal

☐ Stomach ulcers
☐ Nausea/vomiting
☐ Diarrhea
☐ Constipation
☐ Blood in stool
☐ Trouble swallowing
☐ Abdominal pain

Genitourinary

☐ Blood in urine
☐ Pain during urination
☐ Difficulty making urine
☐ Kidney stones

Musculoskeletal

☐ Neck/spine injury
☐ Neck or back disorder
☐ Arthritis

Neurological

☐ Stroke
☐ Mini stroke (TIA)
☐ Temporary loss of vision or speech control
☐ Loss of sensation
☐ Paralysis of an arm or leg
☐ Facial paralysis

Skin

☐ Skin cancers
☐ Dermatitis/eczema

Psychiatric

☐ Clinical depression
☐ Anxiety
☐ Schizophrenia
☐ Hallucinations
☐ Other psychiatric disorder (list) _____

Infectious Disease

☐ Hepatitis
☐ HIV/AIDS
☐ Mononucleosis
☐ TB
☐ Herpes
☐ Syphilis
☐ Gonorrhea
☐ Chlamydia

Have you ever had the following?

☐ Measles
☐ Mumps
☐ Chicken pox