

===== **PERSONAL INFORMATION** =====

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Date of Birth: \_\_\_ / \_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F Married / Single / Divorced

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( \_\_\_\_ ) \_\_\_\_\_ Cell Phone: ( \_\_\_\_ ) \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: ( \_\_\_\_ ) \_\_\_\_\_

Occupation: \_\_\_\_\_ FAX: ( \_\_\_\_ ) \_\_\_\_\_

Spouse: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Referred By: \_\_\_\_\_

===== **PAST MEDICAL HISTORY** =====

Prior Plastic Surgeries: \_\_\_\_\_

Past Medical Illnesses: \_\_\_\_\_

Are you currently being treated for any medical condition (Yes / No)

If yes, please list medical condition and current treatment: \_\_\_\_\_

\_\_\_\_\_

Family History of Illnesses: \_\_\_\_\_

Current Medications: \_\_\_\_\_

**Medication Allergies:** \_\_\_\_\_ **Easy Bruising or Bleeding:** Yes / No

Personal Physician: \_\_\_\_\_ Phone ( \_\_\_\_ ) \_\_\_\_\_

Date of Last Physical Exam: \_\_\_\_\_ By: \_\_\_\_\_

Ever Seen a Psychiatrist or Psychologist?: \_\_\_\_\_ When? \_\_\_\_\_

**PATIENT HEALTH QUESTIONNAIRE**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Recent weight gain or loss: \_\_\_\_\_

Recent Chest X-Ray: (Y / N) Comments: \_\_\_\_\_

Recent EKG: (Y / N) Comments: \_\_\_\_\_

Recent Mammogram: (Y / N) Comments: \_\_\_\_\_

Smoking History: (Yes / No) If yes, please give daily amount: \_\_\_\_\_

Drink Alcohol: (Yes / No) If yes, please give daily amount: \_\_\_\_\_

**Have you ever had the history of the following?:**

- Heart attack, stroke, rheumatic fever..... Y / N
- High/low blood pressure..... Y / N
- History of chest pain..... Y / N
- Do your ankles swell..... Y / N
- Do you get short of breath easily..... Y / N
- Asthma..... Y / N
- Hives, rashes or skin disorders..... Y / N
- Fainting spells or seizures..... Y / N
- Diabetes..... Y / N
- Hepatitis, jaundice, cirrhosis..... Y / N
- Stomach ulcers or heart burn..... Y / N
- Arthritis..... Y / N
- Kidney problems..... Y / N
- Tuberculosis or persistent cough..... Y / N
- Coughing up blood..... Y / N
- Venereal disease..... Y / N
- Emotional disorders..... Y / N
- Excessive bleeding with prior surgery..... Y / N
- Blood disorders or anemia..... Y / N
- Tumors of the mouth, nose or throat..... Y / N
- Hiv/ Aids..... Y / N

If yes to any of the above, please elaborate

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Are you taking any of the following?:**

- Antibiotics..... Y / N
- Blood thinners..... Y / N
- Diet Pills..... Y / N
- Steroids, NSAIDS..... Y / N
- Aspirin, Motrin..... Y / N
- Insulin or Diabetic Meds... Y / N
- Heart Medicine..... Y / N
- Herbal Supplements..... Y / N
- Birth Control Pills..... Y / N
- Hormone Supplements..... Y / N

If Yes to any of the above, please give Name and Dose of medication:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies and Sensitivities**

- Local Anesthetics..... Y / N
- General Anesthetics..... Y / N
- Antibiotics (Penicillin).... Y / N
- Barbiturates, Sedatives.... Y / N
- Morphine or Codeine..... Y / N
- Adhesive Tapes..... Y / N
- Latex..... Y / N

Signature of Patient, Parent or Guardian: \_\_\_\_\_

===== **GUARANTOR INFORMATION** =====

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

**Home Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Social Security No:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Work Address:** \_\_\_\_\_

**In case of an emergency notify:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**I, the undersigned, represent that all of the information on this form is true and complete to the best of my knowledge and belief and that I accept full financial responsibility for professional medical and surgical services rendered.**

**Patient / Insured Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_