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 QUESTIONAIRE

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 seizes………………….. 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: ____________________________________