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BOARD CERTIFIED PLASTIC SURGEON

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■ Patient Information

Today's Date: _____

Title: Dr. Mr. Mrs. Ms. _____ Name (Last, First, Middle) _____

Gender: ☐ M ☐ F Age: _____ Birthdate: _____ Social Security: _____

Street Address _____

City, State & ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email address _____

☐ Check if Minor (less than18) Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Pharmacy Name: _____ Phone: _____

Primary Care Physician (PCP): _____ Phone: _____

Address: _____

Permission to contact PCP regarding care and to inform of treatment course: ☐ Yes ☐ No

■ How did you hear of us?

☐ Friend: _____ ☐ Newspaper: _____

☐ Our patient: _____ ☐ Our Website: _____

☐ Magazine: _____ ☐ Television: _____

☐ Physician referral: _____ Phone: _____

Address: _____

Would you like to receive email announcements on special discounts, new products, or procedures?.....☐ Yes ☐ No

If Yes, what email address can we send it to? _____

■ Authorization

I hereby authorize medical treatment of the person named above, and agree to pay all fees and charges for treatments and services rendered. I understand that medical treatment may include a review of personal, social and medical history, discussion of the reason(s) for the visit(s), and may include photographs of the area(s) being discussed and or treated before and/or after treatment. I have read and agreed to the above.

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____

Please note that we require a copy of your government-issued photo identification for your record.

Patient Name: _____ **Date:** _____

List the reason(s) for your visit today: _____

List all medical conditions for which you are presently being treated: _____

_____

List all skin conditions you have previously been diagnosed with and/or treated for: _____

_____

■ Personal Medical History

Please mark all past and present medical conditions:

Cardiovascular:
- ☐ High blood pressure
- ☐ Heart attack(s)
- ☐ Pacemaker
- ☐ Coronary artery disease
- ☐ Murmur / Mitral valve prolapse
- ☐ Irregular heartbeat / palpitations
- ☐ Other: _____

Pulmonary:
- ☐ Asthma
- ☐ Chronic lung disease
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Sleep Apnea
- ☐ Other: _____

Neuromuscular:
- ☐ Arthritis
- ☐ Muscle weakness
- ☐ Nerve damage
- ☐ Facial paralysis / Weakness
- ☐ Headaches
- ☐ Seizure disorder / Convulsions
- ☐ Spinal / Back disorders
- ☐ Other: _____

Psychological:
- ☐ Depression
- ☐ Anxiety
- ☐ Claustrophobia
- ☐ Receive(d) psychiatric treatment
- ☐ Drug / Alcohol dependency treatment
- ☐ Psychiatric hospitalization
- ☐ Other: _____

Ears / Nose / Throat:
- ☐ Dental Braces / Implants / Crowns
- ☐ Nasal Difficulties
- ☐ Difficulty breathing by nose
- ☐ Difficulty opening mouth
- ☐ Previous nasal injury
- ☐ History of sinus infections
- ☐ Hearing difficulty
- ☐ Hoarseness
- ☐ Other: _____

Eyes:
- ☐ Dry eye
- ☐ Blurred / Double vision
- ☐ Cornea problems
- ☐ Glaucoma
- ☐ Thyroid eye disease
- ☐ Wears glasses or contacts
- ☐ Other: _____

Endocrine:
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Lupus
- ☐ Other: _____

Hepatic:
- ☐ Hepatitis (Type: ___)
- ☐ Pancreatitis
- ☐ Cholecystitis
- ☐ Other: _____

Renal:
- ☐ Renal failure
- ☐ Dialysis
- ☐ Other: _____

Hematology:
- ☐ Anemia - Low hemoglobin
- ☐ Blood Clots
- ☐ Blood transfusion
- ☐ Bleeding disorder
- ☐ Bruise Easily
- ☐ Other: _____

Gastrointestinal:
- ☐ Anorexia/Bulimia
- ☐ Colitis
- ☐ Reflux disease
- ☐ Stomach ulcers
- ☐ Other: _____

Allergic / Immunologic / Infectious:
- ☐ Hay fever
- ☐ HIV / AIDS
- ☐ Sexually transmitted disease
- ☐ Staph / Strep / MRSA
- ☐ Tuberculosis (TB)
- ☐ Autoimmune disorder
- ☐ Other: _____

Dermatological:
- ☐ Excessive sweating
- ☐ Cold sores / herpes
- ☐ Acne
- ☐ Rosacea
- ☐ Eczema
- ☐ Psoriasis
- ☐ Radiation to face / neck
- ☐ Scarring / Keloid formation
- ☐ Slow wound healing
- ☐ Other: _____

Cancer:
- ☐ Basal cell cancer
  Location: _____
- ☐ Squamous cell cancer
  Location: _____
- ☐ Melanoma
  Location: _____
- ☐ Breast cancer
- ☐ Ovarian cancer
- ☐ Lung cancer
- ☐ Colon cancer
- ☐ Prostate cancer
- ☐ Other: _____

Please list any other conditions not listed above: _____

Do you faint easily? ..... ☐ Yes ..... ☐ No

Patient Name: _____ **Date:** _____

For Females Only:

Do you have any personal history of breast cancer? ..... ☐ Yes ..... ☐ No

If yes, who is your treating physician? _____ Phone: _____

Are you still in treatment? ..... ☐ Yes ..... ☐ No

Do you have any family history of breast cancer? ..... ☐ Yes ..... ☐ No

If yes, please list all relatives: _____

When was your last mammogram? _____ Was it normal?..... ☐ Yes ..... ☐ No

Are your currently pregnant? ..... ☐ Yes ..... ☐ No

If no, are you planning to? ..... ☐ Yes ..... ☐ No

Are your currently nursing? ..... ☐ Yes ..... ☐ No

List dates of all pregnancies? _____

Have you ever had a Cesarean (C-Section)? ..... ☐ Yes ..... ☐ No If yes, how many? _____

If yes, when was your most recent Caesarian? ..... ☐ Yes ..... ☐ No

For breast-related surgical patients only: What is your bra size? _____

■ Personal Surgical History

Procedure	Date

Have you ever had any surgical complications? ..... ☐ Yes ..... ☐ No

If yes, please describe: _____

■ Medications

List all medications you are currently taking, both by mouth and topically, including prescriptions (such as birth control, blood thinners, etc.), over-the-counter treatments, vitamins, herbal supplements and creams. Please let us know the reason you are taking each medication.

Medication	Dosage & Frequency	Length of Time Used	Reason Taking Medication

Patient Name: _____ **Date:** _____

Are you currently, or have you recently, taken any medications containing Aspirin? ..... ☐ Yes ..... ☐ No
Have you been on Accutane therapy within the past 24 months? ..... ☐ Yes ..... ☐ No
Have you taken any steroid preparation(s) over the past year? ..... ☐ Yes ..... ☐ No

■ Allergies

☐ **If you have no allergies at all, check this box and skip to the next section.**

If you do have allergies, please check all items that you have had an allergic reaction to:

☐ Penicillin ☐ Sulfa ☐ Lidocaine ☐ Novocaine ☐ Eggs ☐ Latex

If you marked any of the above, please describe the reaction(s): _____

Please list all other drug and food allergies, including products such as tape , and the nature of your reaction:

_____

_____

■ Family Medical History

Please mark which of your relatives have or had the following conditions. List which blood relative are / were affected.

	Mother	Father	Blood Relative(s)
Allergies	☐	☐	_____
Arthritis	☐	☐	_____
Asthma	☐	☐	_____
Cancer (except skin cancer)	☐	☐	_____
Diabetes	☐	☐	_____
Eczema	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Lung Disease	☐	☐	_____
Psoriasis	☐	☐	_____
Tuberculosis	☐	☐	_____
Other skin condition	☐	☐	_____
Basal Cell Carcinoma	☐	☐	_____
Squamous Cell Carcinoma	☐	☐	_____
Melanoma	☐	☐	_____

Were you adopted? ..... ☐ No ..... ☐ Yes If Yes, do you know your biological family's medical history? ..... ☐ No ..... ☐ Yes

■ Social History

Do you smoke? ..... ☐ No ..... ☐ Yes (#/Day: _____) ..... ☐ I did, but I quit (Quitting date: _____)

Do you drink alcohol? ☐ No ☐ Yes If Yes, frequency: _____ Recreational drugs? ☐ No ☐ Yes. If Yes, frequency: _____

How often do you exercise? ..... ☐ Daily ..... ☐ 1 x per week ..... ☐ 2-3 x per week ..... ☐ 4-6 x per week

Do you use sunscreen? ..... ☐ Daily ..... ☐ Always if sunny ..... ☐ Sometimes if sunny ..... ☐ Rarely / Never

What brand facial soap do you use? _____ What brand moisturizer do you use? _____

What brand body soap do you use? _____

Are you using birth control? ..... ☐ No ..... ☐ Yes .....If Yes, method: _____

■ Review of Systems

Have you had any significant weight change in the past year? _____ lb loss _____ lb gain ☐ No

What is your height? _____ What is your current weight? _____