Date_____

Patient's Name _____
Last First Middle Initial

Address _____ Town _____ Zip _____

Home phone_(____)_____ Cell phone _(____)_____

Work phone (____) _____ E-mail _____
*We always maintain patient confidentiality*
Do you give us permission to use your e-mail?
Yes_____ No____ initial_____

Age_____ Sex_____ Date of Birth_____

Social Security #_____ Married ____Single ____Widowed _____Divorced_____

Person financially responsible _____Relationship_____

Occupation_____Employer_____

Business address_____Town_____Zip_____

Spouse or *both* Parent's names_____ SS#_____

Spouse or Parent's employer_____

Employer' address _____Phone _____

Nearest relative not living at same address_____

Relative's address and phone number_____

Family physician_____phone_____

Has anyone in your family been seen or treated at The Plastic Surgery Center? Yes _____No_____

If yes, whom? _____Relationship_____

Name of person or physician who referred you to this office: _____

Reason for visit_____

Have your consulted other physicians, including plastic surgeons, about this? Yes_____ No____

Please list their names_____

***Please read:*** *All charges are due at the time of services. If surgery is indicated, you are responsible for supplying insurance forms to the office.* *The patient is responsible for all fees, regardless of insurance.*

Medical History

**ALLERGIES TO MEDICINE** Yes____ No___
List_____

_____

Allergies to other substances_____

General State of Health Good___ Fair___ Poor___

If not good, please explain_____

_____

_____

Height _____ Weight_____ Weight loss or gain in past year? Loss ____lb Gain ____lb

Date of most recent check up_____ EKG _____Chest X-ray_____

Name and address of physician _____

Serious illness, please list_____

_____

Previous surgery

| Operation | Year | Hospital | City | Surgeon | Anesthesia (local or general) |
|---|---|---|---|---|---|

_____

_____

_____

_____

Have you had significant complications or aftereffects from these operations? Yes_____ No_____

If yes, please explain_____

_____

**Have you ever had any illnesses or disorders of the following?** (Circle if yes)

**(1) Brain** (Including Strokes, Epilepsy) **(2) Face** (paralysis) **(3) Heart or Blood Vessels** **(4) Blood**

**(5)Arms or Legs** **(6) Bones or Joints** **(7) Nervous System** (Including paralysis, numbness **(8) Stomach**

**(9) Intestines/ Bowels** **(10) Liver** **(11) Eyes** (including Glaucoma, dryness) **(12) Urinary System**

**(13) Reproductive System** **(14) Breasts** (include rashes under your breasts, back, neck, shoulder pain headaches etc ) **(15) Endocrine System or Diabetes**

**(16)Ears** **(17) Lungs** (Including asthma) **(18) Nose, Sinuses, Throat**

If circled, please explain: _____

**Family History**

| | Age | State of Health | Has any Relative had: |
|---|---|---|---|
| Mother | | | Tuberculosis……..Yes___ No ___ |
| Father | | | Cancer……...Yes___ No ___ |
| Brother(s) | | | Diabetes ……Yes___ No ___ |
| Sister(s) | | | Epilepsy ……Yes___ No ___ |
| Children (ages) | | | Heart Disease ……Yes___ No ___ |
| | | | High Blood Pressure ……Yes___ No ___ |
| | | | Lung Disease ……Yes___ No ___ |
| | | | Kidney Disease ……..Yes___ No ___ |
| | | | Blood or Bleeding Disorders …Yes___ No ___ |
| | | | Asthma……..……Yes___ No ___ |
| | | | Mental Disorders ……...Yes___ No ___ |

**Medications, Drugs**

What is your daily consumption of the following?

Coffee or Tea_____ Alcohol_____ Tobacco_____

Other intoxicating or mind altering substances (specify)_____

Does anyone in your household smoke? No ___ Yes ___ How much? _____

**PLEASE list all medications**, and their dosages, including: BIRTH CONTROL PILLS, DIURETICS (water pills), BLOOD PRESSURE, or HEART MEDICATIONS, TRANQUISIZERS, HORMONES, BLOOD THINNERS, NOSE DROPS, and SPRAYS, INHALER MEDICINES, ASPIRIN and HERBAL SUPPLEMENTS. Please include any over the counter medications, nutritional supplements or diet pills.

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**PERTINENT PREOPERATIVE INFORMATION**

Have you had a persistent cough that has lasted for more than 2 weeks? ……. No____ Yes____

Have you ever reacted badly to being put to sleep for surgery? ……. No____ Yes____

Has any member of your family reacted badly to being put to sleep for surgery? ……. No____ Yes____

Have you ever had a bad reaction to local anesthetic (Novicaine, etc.)? ……. No____ Yes____

Are you allergic to adhesive tape? ……No____ Yes____

Do you have any allergy to latex? ? ……. No____ Yes____

Are you allergic to suture material such as catgut? ? ……...No____ Yes____

Are you allergic to Bananas, Kiwi, Avocado, or Chestnuts? ……. . No____ Yes____

Do you have high blood pressure?…… No____ Yes____

Are you presently on Birth Control Pills?…….No____ Yes____

Are you presently on Hormonal Replacement Therapy?…… .No____ Yes____

Have you ever taken Accutane of treatment of acne? If yes, date of last dose_____…. .No____ Yes____

Are you presently using Retin A? If yes, date of last application_____……. No____ Yes____

Have you ever had Scarlet or Rheumatic Fever? …… No____ Yes____

Do you bleed or bruise unusually easily (from cuts, surgery, tooth extractions)……..No ____Yes____

Do you form large scars or keloids?……..No ____ Yes____

Do you have any skin diseases, hives, eczema or rash?…….No ____ Yes____

Do you have frequent infections or boils?……. No ____ Yes____

Have you ever taken steroids, cortisone, or ACTH? If so, how long ago? _____ No ____ Yes____

Do you have shortness of breath with walking?…… No ____ Yes____

Do you have, or have you had any back trouble? ……. No ____ Yes____

Does your religion prohibit blood transfusions?…… No ____ Yes____

Do you have or have you ever had any significant emotional problems?……. No ____ Yes____

Have you ever had, or been advised to seek psychiatric care?……...No ____ Yes____

Signature_____

Relationship if other than patient_____