

## PATIENT INFORMATION SHEET

### PERSONAL INFORMATION:

TITLE: (Mr.) \_\_\_\_\_ (Mrs.) \_\_\_\_\_ (Ms.) \_\_\_\_\_ (Miss) \_\_\_\_\_ (Dr.) \_\_\_\_\_

First Name: \_\_\_\_\_

Initial: \_\_\_\_\_ E-Mail: \_\_\_\_\_ Cell #: \_\_\_\_\_

Last Name: \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS# \_\_\_\_\_

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

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

Home Tel: \_\_\_\_\_ Work Tel: \_\_\_\_\_

Referred by: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Drivers Lic # \_\_\_\_\_

Nearest Relative \_\_\_\_\_

Who will be responsible for your account? (Check one) Address \_\_\_\_\_

Self  Spouse  Mother  Father  Other Tel. \_\_\_\_\_

Name: \_\_\_\_\_ SS# \_\_\_\_\_ Tel: \_\_\_\_\_

### INSURANCE COMPANY:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

I.D.# \_\_\_\_\_

Insured Party: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship: \_\_\_\_\_ SS #: \_\_\_\_\_

What is your deductible? \_\_\_\_\_ What is your co-pay? \_\_\_\_\_

Are you insured by any other insurance plan? \_\_\_\_\_

### EMPLOYER INFORMATION:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**ASSIGNMENT:** I hereby assign my insurance benefits to be paid directly to my Doctor. I am responsible for all charges, whether or not paid by my insurance.

\_\_\_\_\_

\_\_\_\_\_

Patient Signature (Parent or Guardian if Minor)

Date

## MEDICAL HISTORY

Name \_\_\_\_\_ Age: \_\_\_\_\_ Wt.: \_\_\_\_\_ Ht.: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Ethnic Background: \_\_\_\_\_

### MEDICAL HISTORY:

Physician: \_\_\_\_\_

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Do you smoke?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Allergy to tape?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you presently in good general health?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you being treated for any illness?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain: _____   |                          |                          |
| 5. Date of last physical exam: _____   |                          |                          |
| 6. Past serious illnesses?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain: _____   |                          |                          |
| 7. Do you drink alcoholic beverages?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Is there any chance that you are pregnant?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you wear contact lenses?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you wear dentures?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Any reaction to anesthesia?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had a blood transfusion?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Allergies to medication?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, please list: _____  |                          |                          |
| 14. List all medications you are taking: _____   |                          |                          |
| 15. List all operations in past: _____   |                          |                          |
| 16. Have you seen other plastic surgeons for the same problem that brings you here today?..... | <input type="checkbox"/> | <input type="checkbox"/> |

### DO YOU HAVE A PAST HISTORY OF:

- |                      | Yes                      | No                       |                        | Yes                      | No                       |
|----------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|
| Headaches            | <input type="checkbox"/> | <input type="checkbox"/> | Reproductive Disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma             | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Disorders  | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure  | <input type="checkbox"/> | <input type="checkbox"/> | Street Drugs           | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding Disorders   | <input type="checkbox"/> | <input type="checkbox"/> | Emotional Problems     | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Problems       | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Infections    | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung Problems        | <input type="checkbox"/> | <input type="checkbox"/> | Bad Scarring           | <input type="checkbox"/> | <input type="checkbox"/> |
| Communicable disease | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid                | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers               | <input type="checkbox"/> | <input type="checkbox"/> | Circulatory problems   | <input type="checkbox"/> | <input type="checkbox"/> |
| Serious injuries     | <input type="checkbox"/> | <input type="checkbox"/> |                        |                          |                          |

Family History of: \_\_\_\_\_ Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart \_\_\_\_\_ Anesthetic Problems  
 Comments: \_\_\_\_\_

### PHYSICAL EXAMINATION

Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Temperature: \_\_\_\_\_

Local Examination: \_\_\_\_\_

HEENT: \_\_\_\_\_ Heart: \_\_\_\_\_

Lungs: \_\_\_\_\_ Extremities: \_\_\_\_\_

Abdomen: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Comments: \_\_\_\_\_

Recommendations: \_\_\_\_\_