The Plastic Surgery Group

Office Use Only: H&P3/12
Dr. # _____
Acct. # _____
B/P _____/_____ T_____P_____R _____
Height _____Weight _____

Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____
Last First Middle

Referred By: _____ Primary Care Doctor: _____

Reason for appointment _____
IF APPLICABLE: Date of injury or onset of problem _____
Is this a result of a work or car accident YES ❑ NO ❑
What makes the problem/pain worse or better _____

Past Medical History: Have you ever been a patient in this office? YES ❑ NO ❑

IF ADDITIONAL SPACE IS NEEDED IN ANY SECTION OF THIS FORM ATTACH A SEPARATE SHEET.

List Any Current Medical Problems You Have:

Medical Problem	Medical Problem

Have you ever had any problem with anesthesia? YES ❑ NO ❑ If yes, explain.

Surgical / Hospitalization History:

Type of Surgery or Hospitalization	Date	Type of Surgery or Hospitalization	Date

Allergies: List medications and/or foods that you are allergic to and what kind of reactions that you have?

Name of Medication	Reaction	Name of Medication	Reaction

Present Medications: (Prescription or Non-Prescription)

Name of Medication	Dosage/Frequency	Name of Medication	Dosage/Frequency

Social History Student YES ❑ NO ❑ Grade Level _____ Full time ❑ Part time ❑
Occupation _____ Employer _____ How Long?_____
Martial Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
Use of Alcohol: ❑ Never ❑ Rarely ❑ Moderate (2 drinks/day) ❑ Heavy (More than 2 drinks/day)
Tobacco Use: ❑ Never ❑ Smoker_____ Packs/Day ❑ Previous Smoker Date Quit _____ ❑ Chews Tobacco ❑ Use Snuff
If you have children ages 0-17 list their ages. _____

Family History
Any family history of medical problems? If so, please list.

Type of problem	Which family member	Type of problem	Which family member

Do you currently have, or have you ever had problems with:

HEENT
- ❑ **ALLERGIC RHINITIS**
- ❑ Blurred/Double Vision
- ❑ **CATARACTS**
- ❑ Chronic Sinusitis
- ❑ Earache
- ❑ Ear Drainage
- ❑ Ear Infections
- ❑ **EYE DISEASE**
- ❑ Eye Injury
- ❑ **GLAUCOMA**
- ❑ Fever Blister
- ❑ Hearing Loss
- ❑ Mouth Sores
- ❑ Nasal Polyps
- ❑ Nose Bleeds
- ❑ Ringing in Ears
- ❑ Wears Glasses/Contacts

Musculoskeletal
- ❑ **ARTHRITIS**
- ❑ Back Injury
- ❑ Back pain
- ❑ Cold Extremities
- ❑ Difficulty Walking
- ❑ **FIBROMYALGIA**
- ❑ Joint Injury
- ❑ Joint Pain
- ❑ Joint Problems
- ❑ Joint Stiffness/Swelling
- ❑ Low back pain
- ❑ Muscle Pain/Cramps
- ❑ Neck Pain
- ❑ **OSTEOPOROSIS**
- ❑ Weakness
- ❑ Weakness of muscles or joints

Psychiatric
- ❑ **ADD**
- ❑ **ADHD**
- ❑ **ALCOHOL ABUSE**
- ❑ **ALZHEIMER'S**
- ❑ **ANXIETY DISORDER**
- ❑ **BIPOLAR DISEASE**
- ❑ **DEPRESSION**
- ❑ **DRUG DEPENDENCY**
- ❑ **INSOMNIA**
- ❑ Memory Loss or Confusion
- ❑ **MENTAL ILLNESS**
- ❑ Nervousness

Cardiac
- ❑ Angina Pectoris
- ❑ **ARTERIAL FIB**
- ❑ Chest pain
- ❑ **CONGESTIVE HEART FAILURE**
- ❑ **CORONARY ARTERY DISEASE**
- ❑ **HEART ATTACK**
- ❑ **HEART DISEASE**
- ❑ **HYPERTENSION** (High Blood Pressure)
- ❑ **HYPOTENSION** (Low Blood Pressure)
- ❑ Irregular Heartbeat
- ❑ **MITRAL VALVE PROLAPSE**
- ❑ Swelling of feet, ankles, hands

Cancer
- ❑ **BRAIN CANCER**
- ❑ **BREAST CANCER**
- ❑ **CERVICAL CANCER**
- ❑ **COLON CANCER**
- ❑ **OVARIAN CANCER**
- ❑ **PROSTATE CANCER**
- ❑ **RECTAL CANCER**
- ❑ **SKIN CANCER**
- ❑ **STOMACH CANCER**
- ❑ **THROAT CANCER**
- ❑ **THYROID CANCER**

Gastrointestinal
- ❑ Abdominal Pain
- ❑ **COLON POLYPS**
- ❑ **DUODENAL ULCER**
- ❑ **GASTRIC ULCER**
- ❑ **GERD**
- ❑ Heartburn
- ❑ **HEPATITIS**
- ❑ **HIATAL HERNIA**
- ❑ **LIVER DISEASE**
- ❑ Nausea & Vomiting
- ❑ **ULCERATIVE COLITIS**

Respiratory
- ❑ **ASTHMA**
- ❑ Chronic or Frequent Cough
- ❑ **COPD**
- ❑ **EMPHYSEMA OF LUNG**
- ❑ Pneumonia
- ❑ Shortness of Breath
- ❑ **SLEEP APNEA**
- ❑ **TUBERCULOSIS**

Hematology
- ❑ Abnormal bleeding in your family
- ❑ **ANEMIA**
- ❑ Bleeding or Bruising Tendency
- ❑ **CLOTTING DISORDER**
- ❑ Deep Venous Blood Clots
- ❑ Known HIV/Aids Exposure
- ❑ Phlebitis
- ❑ Slow to heal after cuts
- ❑ Transfusion History

Skin
- ❑ Change In Skin
- ❑ Rash or Itching
- ❑ **VARICOSE VEINS**

Congenital
- ❑ **CLEFT LIP**
- ❑ **CLEFT PALATE**
- ❑ **EAR DEFORMITY**
- ❑ **FACIAL DEFORMITY**
- ❑ **HAND DEFORMITY**
- ❑ **HEMANGIOMA**
- ❑ **SKULL DEFORMITY**

Endocrine
- ❑ **DIABETES TYPE I**
- ❑ **DIABETES TYPE II**
- ❑ Excessive Thirst
- ❑ Excessive Urination
- ❑ **GLANDULAR HORMONE**
- ❑ Heat or Cold Intolerance
- ❑ **HYPERTHYROIDISM**
- ❑ **HYPOTHYROIDISM**

Neurologic
- ❑ Head Injury
- ❑ **MIGRAINE HEADACHE**
- ❑ Numbness & Tingling
- ❑ **PARKINSON'S DISEASE**
- ❑ **RESTLESS LEG SYNDROME**
- ❑ **SEIZURE DISORDER**
- ❑ **STROKE**
- ❑ Transient Ischemic Attack
- ❑ Tremors

Breast
- ❑ Breast Discharge
- ❑ Breast Pain
- ❑ Cancer
- ❑ **FIBROCYSTIC DISEASE**
- ❑ Lump in Breast

Genitourinary
- ❑ Hematuria
- ❑ Incontinence
- ❑ **KIDNEY DISEASE**
- ❑ Kidney Stones
- ❑ Urinary Frequency
- ❑ Urinary Tract Infections
- ❑ Urinary Tract Problem

PRESCRIPTION REFILL POLICY

Request for Prescription Medications need to be called in to our office between 8:30 a.m. and 4:00 p.m. Monday through Friday. All approved prescriptions, except narcotics, will be called into the pharmacy by the end of that business day. Narcotic prescriptions cannot be phoned in and must be picked up in the office. Prescriptions should be taken "AS DIRECTED". Early refills may be denied. NO medications will be refilled after hours, or on weekends.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Date _____

I have reviewed the above information with the patient.

Physician/ Provider Signature _____ Date _____