Today's date (Month/day/year):					
Patient name:					
(Last)			(First)		(M. I.)
Date of birth (Month/day/year):			**Sex:** ❑Male ❑Female		
How did you hear about our practice?	❑Physician	❑Friend	❑Relative	❑Internet	❑Other
Address:					
Cell Phone:	**Home Phone:**		**Work Phone:**		
Please briefly state the reason for your visit:					
Primary Care Provider:					
Address/Phone:					
Referring Physician:					
Address/Phone:					
Other physicians and specialists: (Dermatologist, Gynecologist, Cardiologist, Psychiatrist, etc.)					

Pharmacy:	Phone:
Address:	Fax:
Emergency contact:	Cell:
Address:	Work:
Relationship:	Home:

Consent to discuss medical care: I authorized Plastic & Reconstructive Surgeons to discuss my medical information with the following individuals I have listed below:

Name:	Relationship:	Phone:

MEDICAL HISTORY:	
Please check conditions below (X) that you currently have OR have had in the past.	
❑ Asthma	❑ Liver disease
❑ Bronchitis/pneumonia	❑ Hepatitis
❑ Emphysema/COPD	❑ Irritable bowel
❑ Tuberculosis	❑ Crohn's disease/ Ulcerative colitis
❑ Cancer	❑ Acid reflux/GERD
❑ Bleeding disorder	❑ Thyroid nodule/goiter
❑ Anemia	❑ Hypothyroidism
❑ Blood clots/DVT	❑ Diabetes
❑ Pulmonary Embolism	❑ Insulin dependent?
❑ Stroke/TIA	❑ Autoimmune disease
❑ Hypertension	❑ Glaucoma
❑ Congestive Heart Failure	❑ Kidney stones
❑ Edema/Swelling	❑ Kidney disease
❑ Varicose veins	❑ Dialysis
❑ Heart attack	❑ Prostate problems (men)
❑ Pacemaker/ Defibrillator	❑ Bladder/kidney infections
❑ Arthritis	❑ Dysplastic nevi
❑ Gout	❑ Basal cell cancer
❑ Joint replacements	❑ Squamous cell cancer
❑ Back/neck problems	❑ Malignant melanoma
❑ Bipolar disorder	❑ Multiple sclerosis
❑ Anxiety/Depression	❑ Myasthenia gravis
❑ Panic attacks	❑ Neuromuscular disease
❑ Alcoholism	❑ Epilepsy/seizures
❑ Drug dependency	❑ Eczema/Psoriasis
❑ HIV	❑ Shingles
❑ Herpes	❑ MRSA

Women Only:	
Last Mammogram:	
Breast Cancer	❑Yes ❑No
Are you currently pregnant:	❑Yes ❑No
Are you taking supplemental estrogen:	❑Yes ❑No
Have you breast-fed in the past year:	❑Yes ❑No
Number of Pregnancies:	Number of miscarriages or stillbirths:
Number of children:	Number of low birthweight babies:

CURRENT MEDICATIONS:		
Please list ALL prescription and/or nonprescription medications, including pain relievers, oral contraceptives, diuretics, laxatives, cold medications, allergy medications, etc.		
Medication	Strength	# pills taken & frequency
Example: Tylenol	500 mg	1 twice a day
Vitamins and Herbal Supplements	Strength	# pills taken & frequency

ALLERGIES:	
MEDICATION/FOOD:	REACTION:
Do you have a tape or adhesive sensitivity?	❑Yes ❑ No
Do you have an allergy to Latex?	❑Yes ❑No
Have you taken aspirin-containing products in the last 2 weeks?	❑Yes ❑No
Have you taken nonsteroidal anti-inflammatory medications (Advil, Motrin, ibuprofen, Naprosyn, etc.) in the last 2 weeks?	❑Yes ❑No
Have you taken steroids or cortisone type drugs within the last year?	❑Yes ❑No
SURGICAL HISTORY:	
Operation:	Date of Surgery:
Have you ever had a blood transfusion?	Year:

FAMILY HISTORY:				
Relation:	Age:	Age at Death:	Cause of Death:	Other Medical Problems:
Father				
Mother				
Brothers				
Sisters				
Sons				
Daughters				

Please check the boxes below if your blood relatives have had any of the following problems:	
❑ Anesthesia problems	❑ Heart disease
❑ Asthma	❑ Kidney disease
❑ Bleeding disorder	❑ Malignant hyperthermia
❑ Breast cancer	❑ Malignant melanoma
❑ Other Cancer	❑ Miscarriage
❑ Clotting disorder	❑ Ovarian cancer ADD
❑ Deep venous thrombosis	❑ Pulmonary embolism ADD
❑ Emphysema/COPD	❑ Skin cancer
❑ Depression	❑ Stroke
❑ Diabetes	❑ Substance abuse
❑ Hypertension	❑ Uterine cancer
Other:	

SOCIAL, EDUCATIONAL, AND WORK HISTORY:					
Marital status:	❑Single	❑Married	❑Divorced	❑Widowed	❑NA
Age of children:					
Employment status:	❑Self-Employed		❑Employed	❑Retired	❑Disabled
Occupation (present or prior):					
Level of education (years of school):					
Do your exercise regularly?	Hours per day:		Hours per day:	Days per week:	
Type of exercise:					
Do you drink alcohol?	❑Yes ❑No ❑Not currently				
	# of drinks per day:			# of days per week:	
Are you a current cigarette smoker?	❑Yes ❑No		Do you want to quit? Have you set a quit date?		❑Yes ❑No ❑Yes ❑No
			Years smoked:	Packs per day:	
Do you use other tobacco products?	❑Yes ❑No		❑Gum/Patch		❑Cigars
			❑E cigarettes		❑Chew
Are you a former smoker?	❑Yes ❑No		Quit date:		
			Years smoked:	Packs per day:	
Do you use recreational drugs?	❑Yes ❑No ❑Not currently			Frequency of use:	
	Drugs:				
Are you sexually active?	❑Yes ❑No ❑Not currently				
Partners:	❑Female ❑Male				
Birth control/protection:	❑Yes ❑No				

INSURANCE INFORMATION:	
Primary Insurance Company:	Subscriber Name:
Group #/Claims #:	Subscriber ID:
Secondary Insurance Company:	Subscriber Name:
Group #/Claims #:	Subscriber ID:

RELEASE OF BENEFITS AND INFORMATION:

I UNDERSTAND IT IS MY RESPONSIBILITY TO MEET THE REQUIREMENTS OF MY INSURANCE PLAN TO ENSURE BENEFITS ARE AVAILABLE FOR SERVICES RENDERED. SOME PLANS MAY REQUIRE ME TO NOTIFY THEM WITHIN 24 HOURS OF TREATMENT IF EMERGENT. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO PLASTIC & RECONSTRUCTIVE SURGEONS, A DIVISION OF PROLIANCE SURGEONS. I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE AND FOR ANY NON COVERED SERVICES. I AUTHORIZE THE DOCTOR AND/OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED FOR THIS CLAIM. MEDICAL INFORMATION MAY BE RELEASED TO YOUR PRIMARY REFERRING PHYSICIAN.

I HEREBY VOLUNTARILY GRANT PERMISSION TO PLASTIC & RECONSTRUCTIVE SURGEONS AND THEIR DESIGNATED REPRESENTATIVES OR EMPLOYEES TO TAKE ANY PREOPERATIVE, INTRAOPERATIVE AND POSTOPERATIVE PHOTOGRAPHS OF MYSELF FOR PURPOSES OF RECORD, EDUCATION, TO ASSIST THE DOCTOR IN THE PERFORMANCE OF MY SURGERY. I AUTHORIZE SUBMISSION OF MY PHOTOGRAPHS TO INSURANCE CARRIERS FOR THEIR USE IN PREDETERMING COVERAGE FOR MY SURGERY. I HEREBY GRANT PERMISSION FOR THE USE OF ANY OF MY PHOTOGRAPHS IN THE CLINIC'S WEBSITE.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

PATIENT SIGNATURE:____

AUTHORIZATION FOR THE TREATMENT OF A MINOR:

I AUTHORIZE PLASTIC & RECONSTRUCTIVE SURGEONS, A DIVISION OF PROLIANCE SURGEONS, TO TREAT THE MINOR PATIENT NAMED ABOVE.

SIGNED BY:_________________________________ RELATIONSHIP:__________________________

Review of symptoms:	Heme/Lymphatics:
☐Yes ☐No Loss of appetite	☐Yes ☐No Easy bruising/bleeding
☐Yes ☐No Night sweats	☐Yes ☐No Persistent swollen glands
☐Yes ☐No Fatigue	☐Yes ☐No Swelling of ankles
☐Yes ☐No Insomnia	☐Yes ☐No Port-a-cath
Eyes:	**Musculoskeletal:**
☐Yes ☐No Eye pain	☐Yes ☐No Joint pain or stiffness
☐Yes ☐No Eye dryness	☐Yes ☐No Positioning concerns
☐Yes ☐No Blurry vision	☐Yes ☐No Muscle spasm or cramps
☐Yes ☐No Double vision	☐Yes ☐No Limited mobility
Ears, Nose, Throat:	**Neurological:**
☐Yes ☐No Difficulty hearing	☐Yes ☐No Frequent headaches
☐Yes ☐No Sore throat	☐Yes ☐No Numbness/tingling
☐Yes ☐No Problematic snoring	☐Yes ☐No Seizures
☐Yes ☐No Heartburn	☐Yes ☐No Paralysis/weakness
☐Yes ☐No Sinus problems	☐Yes ☐No Poor balance
Respiratory:	**Breast/Reproduction:**
☐Yes ☐No Cough or wheezing	☐Yes ☐No Mass or lump in breast
☐Yes ☐No Shortness of breath	☐Yes ☐No Pain in breast
☐Yes ☐No Inhaler/nebulizer	☐Yes ☐No Discharge from nipple
☐Yes ☐No Snoring/sleep apnea	☐Yes ☐No Dimpling of skin
☐Yes ☐No CPAP machine	☐Yes ☐No Retraction of nipple
☐Yes ☐No Supplemental Oxygen	☐Yes ☐No Pregnant?
☐Yes ☐No Inhaler/nebulizer	☐Yes ☐No Multiple/late miscarriages
Cardiovascular:	**Dermatological:**
☐Yes ☐No Chest pain	☐Yes ☐No Changes in moles
☐Yes ☐No Palpitation	☐Yes ☐No Cold sores
☐Yes ☐No Pacemaker/defibrillator	☐Yes ☐No Rash/infection/open wound
Gastrointestinal:	**Psychological/Social:**
☐Yes ☐No Abdominal pain	☐Yes ☐No Anxiety
☐Yes ☐No Frequent heartburn	☐Yes ☐No Mood swings/irritability
☐Yes ☐No Bloating/ Constipation	☐Yes ☐No Depression
☐Yes ☐No Heartburn	☐Yes ☐No Panic attacks
☐Yes ☐No Diarrhea	☐Yes ☐No Daily alcohol use
☐Yes ☐No Feeding tube/ostomy	☐Yes ☐No Recreational drug use
Genitourinary:	**Endocrine:**
☐Yes ☐No Change in urine stream	☐Yes ☐No Unexpected weight change
☐Yes ☐No Incontinence of urine	☐Yes ☐No Fatigue
☐Yes ☐No Frequent urination	☐Yes ☐No Hair loss
☐Yes ☐No Genital lesions/discharge	☐Yes ☐No Excessive thirst
☐Yes ☐No Dialysis	☐Yes ☐No Change in voice
Do you require:	☐Yes ☐No Muscle spasm/dark urine
☐Yes ☐No Wheelchair	☐Yes ☐No High temp after exercise
☐Yes ☐No Walker	☐Yes ☐No Post-op nausea/vomiting
☐Yes ☐No Cane	☐Yes ☐No Motion sickness
☐Yes ☐No Insulin Pump	☐Yes ☐No Recent foreign travel? (3 weeks)
☐Yes ☐No Assistance walking	☐Yes ☐No Exposure to Ebola virus