Center for Plastic Surgery

At Castle Rock

Patient Health Information

Today's Date ____

Name (last, first, MI)

____

Address: ____

City ____

State ____

Zip ____

Phone Number: ____
Email Address: ____
Date of Birth: ____________________ Age: __________________

Marital Status: Single____ Married____ Divorced______Widowed_____

Employer____

Occupation____

Primary Care Physician____

Who can we thank for referring you to our office? ________________________

____

Health Insurance Information (if applicable)

Insurance Company ____

Policy Holder's Name

____

ID # ____________________ Group # ______________

I. General

Specific reason(s) for you are being seen (circle all that apply):

Aesthetic Surgery	Reconstructive Surgery
Face	Breast reconstruction
Small breasts	Skin cancer/lesion
Large breasts	Scars
Sagging breasts	wound
Eyes	
Nose	
Brow	
Neck	
Abdomen	
Lower extremity	
Buttocks	
Other ______________________________	

Have you seen other doctors for this reason? Yes No

If so, who? ______________________________

Have you been previously treated for this problem? Yes No

If so, please indicate: Year/Treatment/Procedure/Physician/Complications

II. Past Medical History

Present Height: ______________ Weight: ______________

Please Indicate if you Have or Had any of the following medical problems:

Eye Problems (e.g. Dry eyes/Glaucoma/Tearing)
Nasal Problems (e.g. Bleeding/Sinusitis/Difficulty breathing/runny nose)
Neurologic/Emotional Problems (e.g. Headaches/Seizures/Depression)
High Blood Pressure
Heart or Circulatory Problems (e.g. Chest pain/Heart Attack/High Cholesterol)
Respiratory Problems (e.g. Asthma/Pneumonia/Shortness of Breath)
Gastrointestinal Problems (e.g. Ulcer/Hernia/Reflux)
Genitourinary Problems (e.g. Voiding problems/Menstrual problems/Impotence/Kidney Stones)
Endocrine/Immune Problems (e.g. Thyroid problems/Diabetes/HIV/Lupus)
Bleeding Problems (e.g. Easy bruising/Clots/Anemia)
Musculoskeletal Problems (e.g. Arthritis/Weakness/Fibromyalgia/Limited Mobility/Numbness/Tingling)
Cancer (please indicate type)____

Please list any additional medical issues and or hospitalizations or emergency visits requiring treatment.

III. Past Surgical History

Have you ever had surgery, including Plastic Surgery? Yes No

If you have had Plastic Surgery, how would you rate your results?
Excellent Good Fair Poor
If your results were fair or poor, please describe briefly.

____

Please list all prior surgical procedures.

____

If you had surgery, check the type of anesthesia and circle any problem(s)

General Anesthesia: Nausea/Vomiting/Slow Awakening/Other
IV Sedation: Nausea/Vomiting/Slow Awakening/Other
Epidural/Spinal: Nausea/Vomiting/Insufficient/Bleeding/Headache/Other
Local: Insufficient/Heart palpitations/Systemic reaction/Other

IV. Medications

Please list all prescription medications

____

____

____

Please list any *non-prescription* medications

____

V. **Allergies and Sensitivities** (what happens?)

Medication Allergies ______________________________

Food Allergies ______________________________

Latex Allergy ______________________________

VI. Social History

Children (birth years)

____

Do you smoke? Yes No

Have you ever smoked? Yes No

If yes, how many cigarettes or packs per day?

____

For how many years? ______________________

If you have quit, how many years/months ago? ______________

Do you drink alcohol? Yes No

If yes, how often? Every day Sometimes Rarely

Do you use any recreational drugs? Yes No

If yes, please indicate:

____

VII. Family History

Do you have a family history of?
Heart problems
Diabetes
Breast cancer
Other cancers
Bleeding problems
Anesthesia problems
Other problems

VIII. Additional Information

____

____

Signature____

My signature certifies that I have completely and accurately filled out the information on this form. I understand that inaccuracies in this information may be detrimental to my care and potentially result in severe medical consequences.