

SQUIRES PLASTIC SURGERY

CONFIDENTIAL PATIENT INFORMATION

Date _____

Last Name _____ First Name _____ MI ____ Nickname _____

SSN# _____ - _____ - _____ DOB ____/____/____ Age _____ Sex _____ Relationship Status _____

Home Address _____

City _____ State _____ ZIP _____

Home Phone _____ Work _____ Cell _____

Occupation _____ Employer/School _____

Which is your preferred contact number? _____

E-mail address _____ @ _____ . _____

Would you like to receive E-mail newsletters periodically offering special discounts and news? Yes, No.

Any restrictions on contacting you ? No, Yes. What restrictions? _____

Who **referred** you or how did you find out about us? _____

If you were referred by a specific person, may we thank them? _____ Yes, No.

SPOUSE/PARENT/SIGNIFICANT OTHER

Last Name _____ First Name _____ Relationship _____

Address _____

City _____ State _____ ZIP _____

Home _____ Work _____ Cell _____ Pager _____

EMERGENCY CONTACT(S)

Same as above, and, or ...

1) Name _____ Relationship _____

Home _____ Work _____ Cell _____

2) Name _____ Relationship _____

Home _____ Work _____ Cell _____

SQUIRES PLASTIC SURGERY - MEDICAL HISTORY

Last Name _____, First _____, DOB _____

Date _____ Reason for Visit _____

Please list all **medications, supplements, vitamins or herbs** you have taken within the last month.

<u>Medication</u>	<u>Dose</u>	<u>Indication</u>	<u>If stopped, when?</u>

Ever taken **Metabolife**? _____ If so, when last taken? _____, Ever taken **Accutane**? _____ If so, when last taken? _____

Allergies: Please list all medications, anesthetics, tapes, or other agents to which you have had an adverse reaction.

<u>Name</u>	<u>Reaction</u>	<u>Approximate date</u>

<u>All hospitalizations and/or operations</u>	<u>Hospital</u>	<u>Date</u>

Other Conditions?

- | | | |
|--|--|--|
| <input type="checkbox"/> Y, <input type="checkbox"/> N - High Blood Pressure | <input type="checkbox"/> Y, <input type="checkbox"/> N - Anemia | <input type="checkbox"/> Y, <input type="checkbox"/> N - Depression |
| <input type="checkbox"/> Y, <input type="checkbox"/> N - Heart Disease / Heart Attack | <input type="checkbox"/> Y, <input type="checkbox"/> N - Blood Clots (DVT) | <input type="checkbox"/> Y, <input type="checkbox"/> N - Mental Disorders |
| <input type="checkbox"/> Y, <input type="checkbox"/> N - Heart Valve Disorder(s), Murmur | <input type="checkbox"/> Y, <input type="checkbox"/> N - Bleeding Disorders, Hemophilia | <input type="checkbox"/> Y, <input type="checkbox"/> N - Dry Eyes |
| <input type="checkbox"/> Y, <input type="checkbox"/> N - Chest Pains, Angina | <input type="checkbox"/> Y, <input type="checkbox"/> N - Easy Bruising /Excessive Bleeding | <input type="checkbox"/> Y, <input type="checkbox"/> N - Glaucoma |
| <input type="checkbox"/> Y, <input type="checkbox"/> N - Irregular Heartbeat | <input type="checkbox"/> Y, <input type="checkbox"/> N - Diabetes | <input type="checkbox"/> Y, <input type="checkbox"/> N - Fainting Spells |
| <input type="checkbox"/> Y, <input type="checkbox"/> N - Shortness of Breath | <input type="checkbox"/> Y, <input type="checkbox"/> N - Kidney or Liver Problems | <input type="checkbox"/> Y, <input type="checkbox"/> N - Stroke, TIA's |
| <input type="checkbox"/> Y, <input type="checkbox"/> N - Asthma | <input type="checkbox"/> Y, <input type="checkbox"/> N - Reflux – Hiatal Hernia | <input type="checkbox"/> Y, <input type="checkbox"/> N - Exposure to hepatitis HIV, AIDS |
| <input type="checkbox"/> Y, <input type="checkbox"/> N - Sleep Apnea, Bad Snoring | <input type="checkbox"/> Y, <input type="checkbox"/> N - Herpes, Fever Blisters | <input type="checkbox"/> Y, <input type="checkbox"/> N - History of IV drug use. |

Please detail those listed above or **any other medical conditions** not listed.

Please list any medical conditions that run in your **family**: Blood clots, Bleeding Disorders, Breast Cancer
Other: _____

Have you or any family member had an unfavorable reaction to **anesthesia**? Yes _____, No _____.
If yes, what? _____

<u>Physicians who care for you</u>	<u>Specialty</u>	<u>Phone</u>

Latest **mammogram** (date) _____ or N/A, -- Latest **EKG** (date) _____ or N/A
 Number of **pregnancies** _____, Live births _____, Ages of children _____, Any more planned? _____
 Do you drink **alcohol**? _____ If so, how many drinks per week? _____, Any other drugs? _____
 Do you **smoke**? _____ if so, how many packs per day? _____, how many years _____ If you quit, when? _____
Height _____, **Weight** _____, How much weight loss _____, or gain _____, have you had over the last 2 years