FOUNDATION for PLASTIC SURGERY PS

Anthony Bared, M.D.

Patient Information

Patient Name: _____ **Date**:_____

Social Sec #_____-_____-_____ **Driver's License #** _____

Birthdate:_____/_____/_____ **Age**:_____**Sex**:_____ **Marital Status**:_____ **Race**:_____

Home Phone # (_____)_____-_____ **Work #** (_____)_____-_____ **Ext**:_____
(**May we contact you at work?)** Yes No

Cell Phone # (_____)_____-_____ **Fax #** (_____)_____-_____

E- Mail:_____

Best Contact Method: (__) **Cell** (__) **Home** (__) **Work** (__) **Email** (__) **Mail**

Local Address:_____ **Apt**:_____

City:_____ **State**:_____ **Zip**:_____

During which months do you typically reside in the area?_____

Permanent Address:_____ **Apt**: _____

City:_____ **State**:_____ **Zip**:_____

Patient Employer:_____ **Occupation**:_____

Spouse's Name:_____ **Employer**:_____ **Phone**:(_____)_____-_____

In case of an emergency, please list a LOCAL family member, neighbor, friend, we may contact.
(***Please list someone other than your spouse listed above***): _____

Relation:_____ **Phone**: (_____)_____-_____

Insurance Information

Company:_____

Telephone:_____

Member Number:_____ **Group Number**:_____

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How were you referred to our office?

(___) **Other** _____
(___) **Doctor**: _____
(___) **Friend (Name)**: _____
(___) **Internet**: _____
(___) **Magazine (Name)**: _____

Health History

Date of Last Physical:_____ **Name of Your Primary Care Physician**:_____

Address:_____

City:_____ **State**:_____ **Zip**:_____

Office Phone # (_____)_____-_____ **Fax** # (_____)_____-_____

Chief Complaint and Areas of Concern:

_____

_____

Type of Procedure Considering:

_____

Past Medical History - Do You Have a History of Any of the Following:

_____Asthma	_____Seizures	_____Hepatitis
_____Hypo/Hyper Thyroid	_____Heart Murmur	_____Rheumatic Fever
_____Heart Disease	_____Myasthenia Gravis	_____Cold Sore/Fever Blisters
_____High Blood Pressure	_____HIV	_____Other, Specify

List any Previous Surgery or Hospitalizations with Approximate Dates:_____

_____

Family History of Major Medical Illness:_____

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Social History

Do You Smoke: (circle) Yes No

If Yes, how much?_____

If you smoked previously, when did you quit?_____

Do You Drink Alcohol:(circle) Yes No

Daily_____ Weekly_____ Weekends_____ Occasionally_____

Current Medications - Please list all medications you are taking prescribed or over-the-counter and the condition for which you take the medications:

_____

Do you have any Drug Allergies: (**circle**) **Yes No**

Allergies: Please List any Allergies or reactions to Any Medication, Drugs, Soaps, Solutions, Food, or Latex, and the reaction you experienced:

_____

If you are currently experiencing any pain, describe below the location and current treatment, and rate your pain on 1-10 scale (**10= most severe**): _____

Review of Systems:

Please indicate if you are experiencing any of the following symptoms.

□ Dizziness	□ Facial pressure	□ Syncope (fainting)	□ Easy Bruising
□ Voice changes	□ Nasal congestion	□ Palpitations	□ Diarrhea
□ Chills	□ Weakness	□ Tinnitus	□ Nosebleeds
□ Fever	□ Mole changes	□ Ear pressure	□ Nausea
□ Weight loss	□ Vertigo	□ Nasal drainage	□ Back pain
□ Joint Pain/Stiffness	□ Painful urination	□ Swelling	□ Chest pain
□ Vomiting	□ Blood in Stool/Urine	□ New lesions	□ Dysphagia (difficulty swallowing)
□ Hearing difficulty	□ Coughing blood	□ Blurred vision	□ Other, Please Specify
□ Shortness of breath	□ Chronic cough	□ Headache	

Height:_____ **Weight**:_____

Have you ever been on Accutane? (Circle) Yes No

If Yes, When ?_____

Women Only

Are you Pregnant: Yes No Are you Taking Birth Control Pills: Yes No

Are you Nursing: Yes No Do You Have Menstrual Problems: Yes No

Signature of Patient:_____ **Date**:_____