

Date: \_\_\_\_\_

**THE PLASTIC SURGERY CENTER**

535 Sycamore Ave., Shrewsbury, NJ 07702 (732) 741-0970, fax (732) 747-2606

Patient's Name: \_\_\_\_\_  
(Last) (First)

Address: \_\_\_\_\_  
(City) (State) (ZipCode)

Home Phone: ( ) \_\_\_\_\_ Cell Phone:( ) \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Do you accept our office's use of your email? Please initial: Yes \_\_\_\_\_ or No \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Married: \_\_\_\_\_ Single: \_\_\_\_\_ Widowed: \_\_\_\_\_ Divorced: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

Spouse or Parent's Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Spouse or Parent's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Person Financially Responsible: Patient \_\_\_\_\_; Parent \_\_\_\_\_; Other \_\_\_\_\_ Name \_\_\_\_\_

Address of Person Financially Responsible: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Other Physician(s) you have seen in the last year: \_\_\_\_\_

Has anyone in your family been seen or treated at The Plastic Surgery Center: Yes \_\_\_\_\_ or No \_\_\_\_\_

If yes, whom? \_\_\_\_\_ Relationship: \_\_\_\_\_

Name of person or physician who referred you to this office: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Have you consulted other physicians, including plastic surgeons, about this? Yes \_\_\_\_\_; No \_\_\_\_\_

If yes, please list their names: \_\_\_\_\_

**ALLERGIES TO MEDICINE** Yes \_\_\_\_\_; No \_\_\_\_\_ **Please list:** \_\_\_\_\_

Allergies to other substances: \_\_\_\_\_

=====

**PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICE. IF SURGERY IS INDICATED, YOU ARE RESPONSIBLE FOR SUPPLYING INSURANCE FORMS TO THIS OFFICE. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE.**

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**MEDICAL HISTORY**

General State of Health: Good \_\_\_\_\_; Fair \_\_\_\_\_; Poor \_\_\_\_\_

If not "Good", please explain and list treating Physician(s) and medications: \_\_\_\_\_

\_\_\_\_\_

Height: \_\_\_\_\_; Weight \_\_\_\_\_ Weight loss or gain in past year? Loss \_\_\_\_\_ lbs.; Gain \_\_\_\_\_ lbs.

Date of most recent check-up: \_\_\_\_\_; EKG \_\_\_\_\_; Chest X-Ray \_\_\_\_\_

Serious illness, please list: \_\_\_\_\_

\_\_\_\_\_

Is there any risk of pregnancy at this time? Yes \_\_\_\_\_ or No \_\_\_\_\_

**Previous Surgery** (Please list):

<u>Operation</u>	<u>Year</u>	<u>Hospital</u>	<u>Surgeon</u>	<u>Anesthesia (Local of General)</u>	<u>Outcome</u>
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Have you had significant complications or aftereffects from any of these operations?

No \_\_\_\_\_ or Yes \_\_\_\_\_

If "Yes", please explain: \_\_\_\_\_

\_\_\_\_\_

**Family History:**

	<u>Age</u>	<u>State of Health</u>	<u>Has any relative had:</u>			
Mother			Tuberculosis	No___ Yes___	Lung Disease	No___ Yes___
Father			Cancer	No___ Yes___	Kidney Disease	No___ Yes___
Brother(s)			Diabetes	No___ Yes___	Asthma	No___ Yes___
Sister(s)			Epilepsy	No___ Yes___	Mental Disease	No___ Yes___
Children			Heart Disease	No___ Yes___	High Blood Pressure	No___ Yes___
			Blood or Bleeding Disorders	No___ Yes___		
			Chronic Headaches?	No___ Yes___		

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## Medications, Drugs:

What is your approximate daily consumption of the following:

Caffeine (coffee, tea, etc.) \_\_\_\_\_; Alcohol \_\_\_\_\_; Tobacco \_\_\_\_\_

Other intoxicating or mood/mind altering drugs or drugs to help concentration (specify) \_\_\_\_\_

Does anyone in your household smoke? No \_\_\_\_\_; Yes \_\_\_\_\_ How much? \_\_\_\_\_

Please list ALL medications, their dosages and the prescribing Physician (including BIRTH CONTROL PILLS, DIURETICS (water pills), BLOOD PRESSURE or HEART MEDICATIONS, TRANQUILIZERS, HORMONE, BLOOD THINNERS, NOSE DROPS and SPRAYS, INHALER MEDICINES, ASPIRIN, and HERBAL SUPPLEMENTS. Please include any over-the-counter medications, nutritional supplements or diet pills:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Pertinent Preoperative Information

Have you had a persistent cough which has lasted for more than two weeks?	No _____; Yes _____	Have you ever had scarlet fever or rheumatic fever:	No _____; Yes _____
Have you ever reacted badly to being put to sleep for surgery?	No _____; Yes _____	Do you bleed or bruise unusually easily (from cuts, surgery, tooth extractions)?	No _____; Yes _____
Has any member of your family ever reacted badly to being put to sleep for surgery?	No _____; Yes _____	Do you occasionally/typically heal with prominent scars or keloids?	No _____; Yes _____
Are you allergic to adhesive tape?	No _____; Yes _____	Do you have any skin disease, hives, eczema or rash?	No _____; Yes _____
Do you have any Latex allergy?	No _____; Yes _____	Do you have frequent infections or boils?	No _____; Yes _____
Are you allergic to Bananas, Kiwi or Chestnuts:	No _____; Yes _____	Have you taken steroid medications, cortisone, or ACTH?	No _____; Yes _____
Do you have high blood pressure?	No _____; Yes _____	Do you have shortness of breath with walking?	No _____; Yes _____
Are you presently on Birth Control Pills?	No _____; Yes _____	Do you have, or have you had any back trouble?	No _____; Yes _____
Are you presently on Estrogen Replacement Therapy?	No _____; Yes _____	Do you have a particular aversion to blood transfusions if medically necessary?	No _____; Yes _____
Have you ever taken Accutane for the treatment of Acne?	No _____; Yes _____	Do you have, or have you had any significant emotional problems?	No _____; Yes _____
Are you presently using Retin A?	No _____; Yes _____	Have you ever had, or been advised to seek psychiatric care?	No _____; Yes _____
Are you on aspirin therapy?	No _____; Yes _____	Do you use NSAIDS (Tylenol, Advil, Motrin, Aleve, etc.) regularly?	No _____; Yes _____
		Do you have any history of migraines or headaches	No _____; Yes _____

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**Have you ever had any illnesses or disorder of the following? (Circle if Yes)**

- |   |                            |  |
|---|----------------------------|--|
| (1) Brain (including strokes, epilepsy)               | (7) Face (paralysis)       | (14) Blood/Blood Vessels   |
| (2) Arms or Legs                                      | (8) Stomach                | (15) Liver   |
| (3) Nervous System<br>(including paralysis, numbness) | (9) Bones or Joints        | (16) Eyes<br>(including glaucoma, dryness)                               |
| (4) Intestines/Bowels                                 | (10) Urinary System        | (17) Endocrine System or Diabetes  |
| (5) Reproductive System                               | (11) Breasts               | (18) Lungs   |
| (6) Ears  | (12) Nose, Sinuses, Throat | (19) Loss of strength in any part of your<br>body                        |
|   | (13) Heart                 | (20) Loss of feeling, numbness or<br>tingling in any parts of your body. |

If circled, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I acknowledge the general nature of surgery. Any surgical procedure may result in pain, scarring, numbness, over-correction, under-correction, and/or the need for correction of asymmetry. I also understand that these complications may be unavoidable and may differ from patient to patient, even in similar/identical procedures that are performed in similar/identical manners.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_  
(Self, Mother, etc.)

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**

Please sign below acknowledging that you have both read and received a copy of The Plastic Surgery Center's Notice of Privacy Practices.

\_\_\_\_\_  
PATIENT'S NAME (Print)

\_\_\_\_\_  
PATIENT OR LEGAL GUARDIAN SIGNATURE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT: (if other than self)

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE SIGNED

**COMMENTS: (FOR STAFF MEMBERS ONLY)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_