

FACIAL PLASTIC AND COSMETIC SURGERY CENTER

PATIENT HISTORY INFORMATION SHEET

ABOUT YOU (Please Print Clearly)

Today's Date ___/___/___

Patient: _____
Last First MI

Social Security Number: _____

Age: ___ Date of Birth: ___/___/___ Sex: Female Male

Home Address: _____
Street

City State Zip

Home Phone Number: _____
Area Code

Cell Phone Number: _____

Office Phone Number: _____

Email: _____

Occupation: _____

Employer: _____

Employer's Address: _____
City State

Whom may we thank for sending you?

Please supply their address if it is convenient:

Marital Status: Married Single

Divorced Widowed

Spouse, Significant Other or Parent's Name:

S, SO or Parent's Home Number: _____

Office Number: _____

Do you have a personal physician? Yes No

Doctor's Name: _____

Address: _____

ABOUT YOUR INSURANCE Please give the receptionist your insurance card(s).

Person Responsible for Account (if different than patient)

Responsible Party: _____
Last First MI

Social Security Number: _____

Home Address: _____
Street

City State Zip

Home Phone Number: _____
Area Code

Cell Phone Number: _____

Office Phone Number: _____

Email: _____

Relationship to Patient: _____

Primary Medical Insurance

Insurance Company: _____

Effective Date of Coverage: ___/___/___

Office Visit Co-Payment: \$ _____

Medicare Number (if Applicable):

Secondary Medical Insurance

Insurance Company: _____

Effective Date of Coverage: ___/___/___

Responsible Party's Date of Birth _____

Employer: _____

Employer's Address: _____
City State

CONSENT OF COMMUNICATON

I give consent to release medical information including test results, diagnosis, surgery scheduling, billing information and treatment dates to the following individuals: (spouse, parent, significant other, etc) PLEASE LIST SPECIFIC NAMES

1. _____
2. _____
3. _____

ABOUT YOUR HEALTH

Present Illness

Please describe the primary reason for your visit today:

Your Social History

- Do you use tobacco? Yes No
- Do you use alcohol? Yes No
- Do you use caffeine? Yes No
- Do you use recreational drugs? Yes No
- Is there added stress in your life? Yes No

ABOUT YOUR MEDICAL HISTORY

Have you had any of these conditions: (Check box for yes or leave blank for no)

General

- Hepatitis
- HIV/ AIDS
- Alcohol/Drug Use/Rehab
- Cancer
- Venereal disease
- Tuberculosis
- Fever, Night Sweats

Ears Nose, Mouth & Throat

- Stuffy nose or sinuses
- Frequent nosebleeds
- Ear pain
- Lump in neck

Respiratory

- Bloody Sputum
- Night Sweats
- Chronic cough or wheezing
- Shortness of breath
- Emphysema or asthma
- Date of Last Chest X-Ray: _____

Psychiatric

- Anxiety or panic attacks
- Depression
- Therapy

Endocrine/Anorexia

- Weight Loss
- Thyroid problems
- Diabetes

Eyes

- Dry eyes
- Blurred or double vision
- Sudden change in vision
- Eye pain

Cardiovascular

- Chest pain
- Heart attack
- Leg pain or cramps
- Congenital heart problem
- Mitral valve prolapse
- High or low blood pressure
- Heart palpitations
- Swelling of legs
- Fatigue

Musculoskeletal

- Neck stiffness or pain
- Swollen joints

Neurological

- Facial paralysis/weakness
- Seizures
- Memory Loss

Hematologic

- Anemia
- Bleeding problems

Other

- Gastrointestinal Problems
- Could you be pregnant?

Allergic

- Local or general anesthesia
- Latex

Allergy to Medication. If so, please list: _____

Are you taking any of the following drugs: (check box for yes and leave blank for no)

- | | | | |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> Antibiotic: _____ | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Arthritis Medicine | <input type="checkbox"/> Heart Medicine | <input type="checkbox"/> Antidepressant Medicine | _____ |
| <input type="checkbox"/> Steroids | <input type="checkbox"/> Insulin/Diabetes Meds | <input type="checkbox"/> Hormone Medicine | |
| <input type="checkbox"/> Pain Medicine | <input type="checkbox"/> Diuretic/Water Pill | <input type="checkbox"/> Medicine for Dizziness | <input type="checkbox"/> Diet: _____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Migraine Medicine | <input type="checkbox"/> Thyroid Medicine | _____ |
| | | <input type="checkbox"/> Diet Pills | |

Please List Current Medications and Include any Dosage and Frequency.

Operations:

Hospitalizations:

Reason _____ Year _____

Reason _____ Year _____

Reason _____ Year _____

Reason _____ Year _____

Reason _____ Year _____

Reason _____ Year _____

Medical History Reviewed by Dr. Simo _____

I, the undersigned, affirm that the information I have given is correct to the best of my knowledge. I authorize treatment of the person named as "patient". I understand that Facial Plastic and Cosmetic Surgery Center will file with my primary insurance company for services rendered and authorize payment of medical insurance benefits directly to FPCSC. I understand that I am responsible for paying any co-payment and deductibles that my insurance does not cover. I authorize FPCSC to obtain or release any information that is related to the treatment of the "patient". A photocopy of this authorization shall be considered as effective and valid as the original document.

Signature _____

_____/_____/_____
Date