

G A L U M B E C K

PLASTIC SURGERY

Patient Information

Date _____ Patient Number _____

First Name _____ MI ____ Last _____

Sex _____ Date of Birth ____/____/____ Age ____ SSN _____-____-_____

Height _____ Weight _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Home (St.) Address _____

City, State, Zip _____

Employer _____

Address _____

Occupation _____

Emergency Contact _____

Relationship to Patient _____

Emergency Contact phone _____

Referred by _____

Reason for today's visit _____

G A L U M B E C K

PLASTIC SURGERY

Health History

First Name _____ MI: ___ Last: _____

Are you allergic to any medications? Yes: ___ No: ___ If yes, please list:

Are you currently taking any medications? Yes: ___ No: ___ If yes, please list:

Do you smoke? Yes: ___ No: ___ If yes, how many packs per day? _____

Do you drink alcohol? Yes: ___ No: ___ If yes, how much? _____

Have you ever used recreational drugs? (Marijuana, Cocaine, etc) Yes: ___ No: ___

If yes, when was the last time? _____

Are you pregnant? Yes: ___ No: ___

Do you have a history of any of the following?

Anemia	Yes	Heart Problems	Yes
Arthritis	Yes	Hiatal Hernia	Yes
Asthma	Yes	High Blood Pressure	Yes
Bleeding Problems	Yes	Kidney Problems	Yes
Bronchitis	Yes	Liver Problems	Yes
Cancer	Yes	Rheumatic Fever	Yes
Diabetes	Yes	Seizures	Yes
Fainting Spells	Yes	Thyroid Problems	Yes
Glaucoma	Yes	Ulcers	Yes

Have you or any member of your immediate family ever had a blood clot (Deep Venous Thrombosis or Pulmonary Embolism)? Yes ___ No ___ If yes please explain:

Do you have any other medical problems not listed here? Yes: ___ No: ___ If yes, please list and explain:

Have you ever had a blood transfusion? Yes: ___ No: ___

Do you have dentures, partial plates or capped teeth? Yes: ___ No: ___

Are you bothered by motion sickness? Yes: ___ No: ___

Have you ever had surgery? Yes: ___ No: ___ If Yes Please list:

Have you or any of your immediate family had any problems with anesthesia? Yes: ___ No: ___
If yes, please list and explain:

Do you have Sleep Apnea? Yes: ___ No: ___

What is the name and address of your personal physician?