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_____

Home (St.) Address _____

City, State, Zip _____

Employer _____

EmployerAddress_____

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	No	Heart Problems	Yes	No
Arthritis	Yes	No	Hiatal Hernia	Yes	No
Asthma	Yes	No	High Blood Pressure	Yes	No
Bleeding Problems	Yes	No	Kidney Problems	Yes	No
Bronchitis	Yes	No	Liver Problems	Yes	No
Cancer	Yes	No	Rheumatic Fever	Yes	No
Diabetes	Yes	No	Seizures	Yes	No
Fainting Spells	Yes	No	Thyroid Problems	Yes	No
Glaucoma	Yes	No	Ulcers	Yes	No

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?