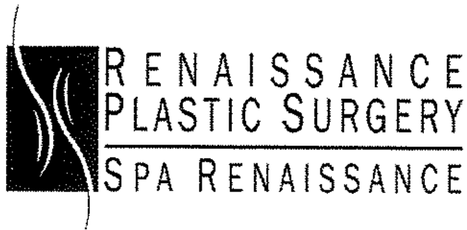

Date:____________________

Full Name:________________________________Age:_____ Date of Birth:___/___/___M___F___

Prefer to be Called:____________________Social Security No.______-_______-________Martial Status: S M D W

Home Address:________________________________City/State:____________________Zip:____________

Home Phone:__________________Mobile:________________*Email:______________________________

*Pharmacy Info:Cross Street/Phone____

Emergency Contact:________________________ Relationship:______________Phone:____________

Insurance:________________________ Responsible Party:__________________________________

Date of Birth:______________Employer:______________________Soc.No.____________________

Is this visit result of a work related injury? YES_____NO_____Date of Injury:____________________

**Do you smoke or use tobacco in any form? YES / NO
Do you form large scars / keloids? YES / NO
Do you have frequent boils/infections? YES / NO
Do you exercise regularly? YES / NO How often? NEVER/OCCASIONALLY/FREQUENTLY
Do you drink alcoholic beverages? YES / NO How often? NEVER/OCCASIONALLY/FREQUENTLY
Have you had Cosmetic Surgery? YES / NO
Surgeon's Name:______________________________

Are you allergic to any Medications/Products? YES / NO

____

List all current Medications you are taking / Including supplements:

____

____

Dermatologist Name:______________________________Name & Address of Primary Care / Treating Physcians:

____

____

Family and Personal Health History

Please identify any medical problems you or any blood relative have or have had

Condition	Self/Family Member(s)	Condition	Self/Family Member(s)
Asthma	______	Lung Disease	______
Anemia/Blood disorders	______	Mental Disease/Disorder	______
Birth Defects	______	Muscle Disorder	______
Bone/Joint Disorder	______	Rheumatic Fever	______
Cancer	______	Rheumatoid Arthritis	______
Diabetes	______	Seizures	______
Ear/Eye Disorder	______	Skin Disease	______
Heart Disease/Problems	______	Thyroid Disease	______
High Blood Pressure	______	Tuberculosis (TB)	______
HIV/AIDS	______	Venereal Disease (VD)	______
Kidney Disease/Problems	______		

Pregnancy: (Past) __________ (Future?) ____________ Number of Children________ Height: ______ Weight: ______

Surgical History: ____

PLEASE NOTE: It is mandatory for patients (who smoke) to quit smoking two weeks prior to surgery and a MINIMUM of two weeks after surgery. IF YOU THINK YOU CANNOT REFRAIN FROM SMOKING THIS LONG PLEASE LET US KNOW.

Yes, I can refrain from smoking ____ No, I cannot ____

Doctor's Notes

Breast Patients Current Bra Size: ______________ Goals ________________ Last Mammogram________________

Nipple to Sternal Notch: (left) ________ (right) ________ Location of Exam ________________

Base Width: ________ Nipple to Fold (left) ________ (right) _________

ONCOLOGIC DATA

Family Hx of Breast CA Y/N ____________

PRIOR BREAST BIOPSIES/MASSES Y/N ____________

Breast Pain Y/N ____________

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any change in my medical or health insurance status. I am also aware that I am fully responsible for all medical expenses incurred and I agree to pay all charges submitted by this office during the course of treatment. I, the patient/responsible party authorize the release of any medical information required to process a claim for payment. I, the patient/responsible party authorize payment or medical benefits to the physician/supplier for services rendered.

______________________________ ______________
Signature Date

______________________________ ______________
Signature of Parent or Guardian Date
ONLY IF PATIENT IS A MINOR