

(Please Print)

**PATIENT INFORMATION**



*Savannah  
Plastic Surgery*

7208 Hodgson Memorial Dr.  
Savannah, GA 31406  
www.SavannahPlasticSurgery.com  
1-800-424-8478

Date \_\_\_\_\_

Doctor \_\_\_\_\_

Patient's Name:	Marital Status				Date of Birth	Age	Sex
	S	M	D	W			

Email address	Home Phone No. ( )
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Street Address <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	City and State	Zip Code	Business Phone No. ( )
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Patient's Employer	Occupation	How Long Emp.?	Cell Phone No. ( )
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Employer's Street Address	City and State	Zip Code	Social Security No.
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Primary Care Physician	PCP Phone #	Spouse's Name	Spouse's Date of Birth
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How did you hear about us?

Spouse's Employer	Employer's Street Address	City and State	Zip Code
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Spouse's Occupation	How Long Emp.?	Spouse's Business Phone No. ( )	Spouse's Social Security No.
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In Case of Emergency Contact (Not living with you)	Relationship	Home Phone ( )	Business Phone ( )
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Contact's Street Address	City and State	Zip Code
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**IF THE PATIENT IS A MINOR OR STUDENT**

Mother's Name	Street Address, City, State and Zip Code	Home Phone No. ( )
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Mother's Employer	Occupation	How Long Emp.?	Business Phone No. ( )
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Employer's Street Address, City, State and Zip Code	Social Security No.
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Father's Name	Street Address, City, State and Zip Code	Home Phone No. ( )
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Father's Employer	Occupation	How Long Emp.?	Business Phone No. ( )
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Employer's Street Address, City, State and Zip Code	Social Security No.
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PATIENT HISTORY

Name \_\_\_\_\_

Age \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_

Chief Complaint: For what reason are you seeing the doctor today? \_\_\_\_\_

PAST MEDICAL HISTORY

List any medications to which you are allergic: \_\_\_\_\_

Foods? \_\_\_\_\_ Other \_\_\_\_\_

What medications do you currently take? \_\_\_\_\_

Have you ever had a blood transfusion before? \_\_\_\_\_ When? \_\_\_\_\_

Have you ever had a blood transfusion reaction? \_\_\_\_\_ When? \_\_\_\_\_

Have you had or presently have any of the following? (check)

- Checkboxes for various medical conditions: Aids or tested HIV positive, Diabetes, Cancer, Tuberculosis, Pneumonia, Epilepsy, Hepatitis, Anemia, Heart Disease, Lung Disease, Muscle Disease, Nervous Conditions, Kidney Disease, Liver Disease, Skin Cancer, Mental Illness, Heart Murmur, Irregular Heart Beats, High Blood Pressure, Bleeding Tendencies, Stomach/Intestinal Disease, Rheumatic Fever, Cancer of Breast, Heart Attack, Stroke, Thyroid Disease, No. of pregnancies, No. of living children, Last tetanus, Last menstrual period.

Are you pregnant? \_\_\_\_\_ Date of last mammogram \_\_\_\_\_

List any childhood illnesses you have had: \_\_\_\_\_

Children - Are immunizations current? \_\_\_\_\_

List any serious injuries you have received and when they occurred: \_\_\_\_\_

List any operations and when they took place: \_\_\_\_\_

Hospitalizations other than for surgery: \_\_\_\_\_

FAMILY HISTORY

Table with 6 columns: Family Member, Age, Living, Dead, Cause of Death, Major Diseases. Rows include Father, Mother, Sisters, Brothers.

Check any illnesses that have affected any close relatives (parents, siblings):

- Checkboxes for family illnesses: Cancer, Heart Attacks, Strokes, Diabetes, Hemophilia, Heart Disease, Rheumatic Fever, Sickle Cell Anemia, Bleeding Tendencies, High Blood Pressure, Brain Hemorrhage, Breast Cancer, Others.

**SOCIAL HISTORY**

Do you live alone? \_\_\_\_\_ Occupation: \_\_\_\_\_

Habits: Smoking:  Yes  No  Cigarettes  Pipe  Cigars  Other

How much? \_\_\_\_\_

Former Smoker? \_\_\_\_\_ When did you stop? \_\_\_\_\_ How Long? \_\_\_\_\_

Alcohol:  None  Occasionally  Frequently How much? \_\_\_\_\_

Please answer the following regarding your health:

- 1. Have you had recent fevers or chills? .....  Yes  No
- 2. Have you had a significant change in weight? .....  Yes  No  
Increase or Decrease (circle one) How much? \_\_\_\_\_
- 3. Do you have tearing, dry eyes, wear contacts or glasses? (circle one).....  Yes  No
- 4. Do you have problems with your hearing, sore throats, congested sinus or snoring? (circle one) .....  Yes  No
- 5. Do you get tightness, pressure, or squeezing in your chest? .....  Yes  No
- 6. Are you under treatment for high blood pressure? .....  Yes  No
- 7. Do you frequently suffer from chest colds, chronic coughing,  
bronchitis, asthma or difficulty breathing? (circle one) .....  Yes  No
- 8. Have you had diarrhea, nausea or vomiting? (circle one) .....  Yes  No
- 9. Have you had a recent change in bowel habits? .....  Yes  No
- 10. Do you have burning with urination? .....  Yes  No
- 11. Do you have pain in the joints, muscle aches or spasms? .....  Yes  No  
Where? \_\_\_\_\_
- 12. Have you noticed a change in a mole or skin lesion? .....  Yes  No  
Describe \_\_\_\_\_  
(size, color, shape, itching or bleeding)
- 13. Have you had excessive exposure to the sun or a tanning bed? .....  Yes  No
- 14. Have you had or do you have a breast lump? .....  Yes  No
- 15. Do you perform a regular breast self-examination? .....  Yes  No
- 16. Are you under treatment for depression? .....  Yes  No
- 17. Have you ever had a problem with bleeding or blood clotting? .....  Yes  No
- 18. Has anyone in your family had bleeding tendencies or hemophilia? .....  Yes  No

Please list any additional information you feel is pertinent to your care: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

