

(Please Print)

PATIENT INFORMATION



*Savannah
Plastic Surgery*

7208 Hodgson Memorial Dr.
Savannah, GA 31406
www.SavannahPlasticSurgery.com

Date _____

Doctor _____

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

Email address	Home Phone No. ()
---------------	-----------------------

Street Address <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	City and State	Zip Code	Business Phone No. ()
--	----------------	----------	---------------------------

Patient's Employer	Occupation	How Long Emp.?	Cell Phone No. ()
--------------------	------------	----------------	-----------------------

Employer's Street Address	City and State	Zip Code	Social Security No.
---------------------------	----------------	----------	---------------------

Primary Care Physician	PCP Phone #	Spouse's Name	Spouse's Date of Birth
------------------------	-------------	---------------	------------------------

How did you hear about us?

Spouse's Employer	Employer's Street Address	City and State	Zip Code
-------------------	---------------------------	----------------	----------

Spouse's Occupation	How Long Emp.?	Spouse's Business Phone No. ()	Spouse's Social Security No.
---------------------	----------------	------------------------------------	------------------------------

In Case of Emergency Contact (Not living with you)	Relationship	Home Phone ()	Business Phone ()
--	--------------	-------------------	-----------------------

Contact's Street Address	City and State	Zip Code
--------------------------	----------------	----------

IF THE PATIENT IS A MINOR OR STUDENT

Mother's Name	Street Address, City, State and Zip Code	Home Phone No. ()
---------------	--	-----------------------

Mother's Employer	Occupation	How Long Emp.?	Business Phone No. ()
-------------------	------------	----------------	---------------------------

Employer's Street Address, City, State and Zip Code	Social Security No.
---	---------------------

Father's Name	Street Address, City, State and Zip Code	Home Phone No. ()
---------------	--	-----------------------

Father's Employer	Occupation	How Long Emp.?	Business Phone No. ()
-------------------	------------	----------------	---------------------------

Employer's Street Address, City, State and Zip Code	Social Security No.
---	---------------------



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: Name, 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 _____

