

# INFORMATION FOR CASE HISTORY FILE

(PLEASE complete **all items**. PLEASE print.)

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Email Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Local Florida Address \_\_\_\_\_ City \_\_\_\_\_

Usual months in town \_\_\_\_\_ Zip \_\_\_\_\_ Local Phone \_\_\_\_\_

Permanent Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Permanent Phone \_\_\_\_\_

Married  Single  Widowed  Divorced  Separated  Social Security # \_\_\_\_\_

Patient's Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Patient Referred by \_\_\_\_\_

Family Doctor or Internist \_\_\_\_\_ Address \_\_\_\_\_

Has this office ever seen or treated any member of your family? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, whom? \_\_\_\_\_

(Name)

(Relationship)

Emergency Contact \_\_\_\_\_ Their Phone # \_\_\_\_\_

(Name)

(Relationship)

Primary Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_ Policy No. \_\_\_\_\_

Insured's Employer \_\_\_\_\_ D.O.B. \_\_\_\_\_ Relationship \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_ Policy No. \_\_\_\_\_

Insured's Employer \_\_\_\_\_ D.O.B. \_\_\_\_\_ Relationship \_\_\_\_\_

Person Financially Responsible Patient  Spouse  Parent  Other

If "Other", please complete the following:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

(Party financially responsible)

Address \_\_\_\_\_

(Street)

(City)

(State)

(zip)

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

## PRESENT PROBLEM

Problem(s) for which you are seeking plastic surgery \_\_\_\_\_

Have you consulted any other doctors, including plastic surgeons, about this? No \_\_\_\_\_ Yes \_\_\_\_\_

(If yes, please list their names) \_\_\_\_\_



**INJURIES**

Type	Year	Hospital	Doctor	After-Effects

**FAMILY HISTORY**

Age	State of Health (or cause of death)	Has any relative had:	
Mother _____	_____	Blood Disease .....	No _____ Yes _____
Father _____	_____	Tuberculosis .....	No _____ Yes _____
Brother(s) _____	_____	Cancer .....	No _____ Yes _____
_____	_____	Diabetes .....	No _____ Yes _____
Sister(s) _____	_____	Epilepsy .....	No _____ Yes _____
_____	_____	Heart Disease .....	No _____ Yes _____
Children _____	_____	High Blood Pressure .....	No _____ Yes _____
_____	_____	Lung Disease .....	No _____ Yes _____
_____	_____	Kidney Disease .....	No _____ Yes _____
_____	_____	Asthma .....	No _____ Yes _____
_____	_____	Mental Disease .....	No _____ Yes _____

**MEDICATIONS, DRUGS**

What is your approximate daily consumption of the following:

Tobacco \_\_\_\_\_

Alcohol \_\_\_\_\_

Coffee or Tea \_\_\_\_\_

Please list **all** medications you are taking (including blood thinners, aspirin, Bufferin, birth control pills, diuretics (water pills) blood pressure or heart medications, tranquilizers, hormones, herbal remedies, etc.

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**PERTINENT PREOPERATIVE INFORMATION**

Are you allergic to any medicines? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, which one(s)? \_\_\_\_\_

- Do you have asthma or hay fever? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Have you ever had a bad reaction to a general anesthetic (gas, Pentothal, etc.)? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Has any member of your family ever had any bad reaction to a general anesthetic? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Have you required unusually large amounts of local anesthetic for medical or dental procedures? No \_\_\_\_\_ Yes \_\_\_\_\_
- Have you ever had a bad reaction to a local anesthetic (Novocain, etc.)? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Are you allergic to adhesive tape? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Do you have high blood pressure? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Have you ever had Scarlet Fever? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Have you ever had Rheumatic Fever? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Do you bleed unusually easily (from cuts, surgery, tooth extractions)? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Have you ever had phlebitis, blood clots in legs, or pulmonary emboli? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Do you bruise unusually easily? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Are you a slow or poor healer? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Do you form large scars or keloids? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Do you have any skin disease, hives, exzema or rash? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Do you have frequent infections or boils? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Have you taken steroid medications, cortisone or ACTH? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Do you have shortness of breath? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Do you have, or have you had, any significant emotional problems? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Have you ever had psychiatric care? ..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Have you ever been advised to see a psychiatrist? ..... No \_\_\_\_\_ Yes \_\_\_\_\_

Have you had any illnesses of the following? (Circle if Yes)

Brain	Nose	Chest	Stomach	Bladder	Arms
Eyes	Throat	Lungs	Intestines	Legs	Reproductive System
Ears	Neck	Heart	Kidney	Nervous System	

If circled, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf for any services furnished to me by my plastic surgeon.

I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents or any other insurance company, any information needed to determine these benefits for related services.

I hereby authorize payment directly to my plastic surgeon of benefits otherwise payable to me. I understand and agree that any unpaid balance not covered by Medicare and/or other insurance will be payable by me.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Beneficiary)