LAKEVIEW PLASTIC SURGERY

Alison Shore, MD

PATIENT INFORMATION

Today's Date ___/___/___

Name: ____
Last First M.I.

Mailing Address:

____
Street City State Zip Code

Home Phone: (___) _______________ Ok to leave message? ❑ Yes ❑ No
Work Phone: (___) _______________ Ok to leave message? ❑ Yes ❑ No
Cell Phone: (___) __________ Ok to leave message? ❑ Yes ❑ No

Email address: ____ Occupation: ____________________

Date of Birth: ____/____/____ Marital Status: ________ Spouse/Partner Name: ____________

Age: ______ Sex: ____________ ___ Gender: ______________

PATIENT OR RESPONSIBLE PARTY (if different from patient)

Name: ____
Last First M.I.

Mailing Address:

____
Street City State Zip Code

Home Phone: (___) _______________ Ok to leave message? ❑ Yes ❑ No
Work Phone: (___) _______________ Ok to leave message? ❑ Yes ❑ No
Cell Phone: (___) _______________ Ok to leave message? ❑ Yes ❑ No

Date of Birth: ____/____/____ Marital Status: ___________________ Spouse Name: ____________________

In case of Emergency, who should be notified? ________________________________ **Phone** (_____) ____-_________

Can we discuss your medical conditions with other members of your household? ❑ Yes ❑ No ❑ Specify: _________________

Referred by: ❑ Physician ______________________________ ❑ Family/Friend ________________________________

How did you hear about us?
❑ Friend/Family ❑ Internet or Social Media ❑ Advertisement ❑Insurance Referral ❑ Physician
❑Other __________________________

AUTHORIZATION

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

In order to establish optimal relationships with our patients and avoid misunderstanding and confusion regarding out payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in an insurance plan in which we participate. For those patients, applicable copayments will be collected. We accept payment in the form of cash or credit card. If we do accept a check for payment, and the check does not clear the bank, a $25.00 service fee will be automatically added to your account. Please note that any procedures performed in the office may be billed separately and in addition to the office visit fee. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature ____ Date: ____/____/__________

If patient is a minor, print name of responsible party ______________________________ Relationship ______________

NEW PATIENT MEDICAL QUESTIONNAIRE

Patient Name: ____ **Date of Birth:** ______________
What name do you go by? ____ **Pronouns:** ________________

Today's Date:_____________________ **Weight:** _________________
Height: __________________

Reason for Visit: ____

SOCIAL HISTORY

Do you use nicotine in any form? Yes No If yes, what kind and how often? _____________________
Do you use marijuana? Yes No If so, which kind(s)?_________________________________

Do you drink alcohol? Yes No If yes, how many drinks (average) per week? ____________
Do you have a history of illegal drug use? Yes No
Do you have a history of dependence? Yes No

PHARMACY INFORMATION

Pharmacy Name: ____ **Tel**: __________________________
Address: ____

MEDICATIONS AND SUPPLEMENTS

Please list all medications and supplements you are currently taking.

Name of Medication	Dose and Frequency	Reason for taking

Do you take any blood thinners?

____ No ____ Coumadin ____ Aspirin ____ Other: _____________________________

ALLERGIES

_____ I have no known allergies
_____ I have the following allergies:

Medication/Substance	Reaction

FAMILY HISTORY

Does or did anyone in your family have any of the following conditions?

Condition	Relationship	Description
❑ Cancer		
❑ Bleeding or clotting disorders		

MEDICAL HISTORY

Are you currently having any problems or conditions related to the following?

Constitutional

Fevers	Yes	No	In the Past
Chills	Yes	No	In the Past
Weight gain/loss	Yes	No	In the Past
Excessive fatigue	Yes	No	In the Past
Ongoing Infection	Yes	No	

Endocrine

Diabetes/High blood sugar	Yes	No	In the Past
Thyroid problems	Yes	No	In the Past
Excessive Thirst	Yes	No	In the Past

Cardiovascular

Chest pain (angina)	Yes	No	In the Past
Heart failure (CHF)	Yes	No	In the Past
Irregular heartbeat	Yes	No	In the Past
High blood pressure	Yes	No	In the Past
Low blood pressure	Yes	No	In the Past
Blood clots (DVT or PE)	Yes	No	In the Past
Bleeding disorders	Yes	No	In the Past

Respiratory

Wheezing	Yes	No	In the Past
Coughing	Yes	No	In the Past
Shortness of breath	Yes	No	In the Past

Breast

Breast pain	Yes	No	In the Past
Nipple discharge	Yes	No	In the Past
Breast lumps or masses	Yes	No	In the Past
Abnormal mammogram	Yes	No	In the Past

Neurological

Headaches	Yes	No	In the Past
Dizzy spells	Yes	No	In the Past
Numbness/Tingling	Yes	No	In the Past

Eyes

Blurred vision	Yes	No	In the Past
Double vision	Yes	No	In the Past

Gastrointestinal

Abdominal pain	Yes	No	In the Past
Heartburn/indigestion	Yes	No	In the Past
Abnormal bowel mvmts	Yes	No	In the Past

Integument (Skin)

Rashes	Yes	No	In the Past
Acne	Yes	No	In the Past
Persistent itching	Yes	No	In the Past
Psoriasis	Yes	No	In the Past

Psychologic

Depression	Yes	No	In the Past
Suicidal thoughts	Yes	No	In the Past
History of self harm?	Yes	No	In the Past

Genitourinary

Urinary frequency	Yes	No	In the Past
Urinary retention	Yes	No	In the Past
Painful urination	Yes	No	In the Past
Unusual vaginal discharge	Yes	No	In the Past
Unusual vaginal bleeding	Yes	No	In the Past

Medical Conditions	Medical Conditions

Surgery/Procedure	Date	Reason for surgery

Have you ever had a complication related to anesthesia? Yes No

If yes, please explain:____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE OF PATIENT, PARENT or GUARDIAN: ______________________________ **DATE**: ____________