ELIZABETH INSTITUTE

Plastic & Reconstructive Surgery

Patient _____ Date of Birth _____
First Middle Last

Nickname _____ Social Security # _____

□ male □ female Do you live alone? □ Yes □ No □ Hispanic □ Non- Hispanic □ Declined

□ White □ Hispanic □ African American □ Native American □ Asian □ Other □ Declined

Home Address _____ City/State/Zip Code _____

Home Phone _____ Cell Phone _____

E-Mail Address _____ Business Phone _____

May we contact you by E-mail □ Yes □ No Preferred Phone □ cell □ home

May we leave you telephone messages concerning your visit? □ Yes □ No

Occupation _____ Employer_____

□ Married □ Divorced □ Widowed □ Single □ Separated □ Domestic Partner

Whom may we thank for referring you? _____

Emergency Contact _____ Relationship _____ Phone _____

Primary Physician _____ located in (city) _____

Please describe the main reason for your visit today _____

Please indicate if your parent, immediate family member or grandparent has had any of the following:

cancer	Y	N	heart disease	Y	N	diabetes	Y	N
stroke /TIA	Y	N	high blood pressure	Y	N	anesthesia issue	Y	N
renal failure	Y	N	psychiatric	Y	N	thyroid	Y	N

Please list all the prescription and /or non-prescription medications and vitamins you take.

Name of Medication	Dose	How often?

Do you have any known drug allergies? □ Yes □ No Do you use birth control? □ Yes □ No

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List all allergies (including medications, dyes, latex)

Allergy	Reaction

Are there any medications you do not wish to take? _____

Have you had surgery before? Please list the surgery and the year it was done.

Surgery	Year

Have you had any of the following conditions in the last 18 months; answer yes or no.

chills	Y	N	diarrhea	Y	N	swollen joints	Y	N
fatigue	Y	N	ulcers	Y	N	arthritis	Y	N
fever	Y	N	loss of appetite	Y	N	neck stiffness pain	Y	N
weight gain	Y	N	diabetes	Y	N	dropping objects	Y	N
ear pain	Y	N	hair changes	Y	N	easy bleeding	Y	N
hearing loss	Y	N	increased thirst	Y	N	hepatitis	Y	N
nasal drainage	Y	N	head injury	Y	N	HIV/AIDS	Y	N
visual changes	Y	N	dizziness	Y	N	steroid use	Y	N
dry or watery eyes	Y	N	migraine headache	Y	N	history of blood clots	Y	N
glaucoma	Y	N	stroke	Y	N	healing problems	Y	N
chronic cough	Y	N	seizures	Y	N	accutane use last 12 months	Y	N
known TB exposure	Y	N	anxiety	Y	N	environmental allergies	Y	N
Shortness of breath	Y	N	depression	Y	N	food allergies	Y	N
wheezing	Y	N	suicidal thoughts	Y	N	seasonal allergies	Y	N
chest pain	Y	N	changing spots	Y	N	malignant hyperthermia	Y	N
heart attack	Y	N	rash	Y	N	anesthesia problems	Y	N
edema	Y	N	skin lesion	Y	N	other:		
palpitations	Y	N	breast mass	Y	N	other:		
abdominal pain	Y	N	breast discharge	Y	N	other:		
constipation	Y	N	nursing	Y	N	other:		

Could you be pregnant? □ Yes □ No Weight _____ Height _____

Do you drink alcohol? □ Yes □ No Do you use caffeine? □ Yes □ No

Do you use recreational drugs? □ Yes □ No Do you use marijuana? □ Yes □ No

Do you smoke? □ Yes □ No How much? _____ Quit? _____ Nicotine use? □ Yes □ No

What pharmacy would you like to use if you need a prescription? _____

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I, the undersigned, affirm that the information I have given is correct to the best of my knowledge. I authorize treatment of the person named as "patient". I understand that Elizabeth Institute, LLC will file with my primary insurance company for services rendered and authorize payment of medical insurance benefits directly to Elizabeth Institute, LLC. I understand that I am responsible for paying any co-payment and deductibles that my insurance does not cover. I authorize Elizabeth Institute, LLC to obtain or release any information that is related to the treatment of the "patient". A photocopy of this authorization shall be considered as effective and valid as the original document.

_____	_____	_____
Signature	Print Name	Date

I have reviewed the above medical information with the patient or their guardian

_____	_____
Margo Herron, MD	Date

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