

New Patient Form

Name: _____ Date of Birth: _____

Email Address: _____

Pharmacy Name and Address: _____

Pharmacy Phone: _____

How were you referred to our practice? _____

Please list your physicians below:

Primary Care: _____

OB/GYN: _____

Prior Plastic Surgeon: _____

Reason for visit: _____

Have you seen or are you planning to see any other plastic surgeons?

Yes or No

If yes, which one(s) _____

What is your current bra size (band and cup)? _____ Desired bra size? _____

How many pregnancies? _____ How many deliveries? _____

Did you breast feed? Yes No If yes, how many times? _____

Have you ever had a miscarriage? Yes No If yes, how many? _____

Have you or any family members ever had a blood clot? Yes No

If yes, please explain: _____

Medical problems, please circle yes or no:

Diabetes	Yes	No	Arthritis	Yes	No
Heart disease	Yes	No	High cholesterol	Yes	No
Asthma or COPD	Yes	No	Kidney disease	Yes	No
High blood pressure	Yes	No	Bleeding disorder	Yes	No
Thyroid disease	Yes	No	Hepatitis B or C	Yes	No
Anemia	Yes	No	Depression	Yes	No
Other cancer	Yes	No	HIV	Yes	No

Other, please list: _____

Previous surgeries, please list:

Procedure:	Date:	Procedure:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Medications, please list:

Drug:	Dose/Frequency:	Drug:	Dose/Frequency:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Drug allergies, please list:

Drug:	Reaction:	Drug:	Reaction:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family history (1st degree relatives – parents, siblings, or children):

Diabetes	Yes	No	If yes, who: _____
Heart disease	Yes	No	If yes, who: _____
High blood pressure	Yes	No	If yes, who: _____
Breast cancer	Yes	No	If yes, who: _____
Other cancer	Yes	No	If yes, who & type: _____
Anesthesia problems	Yes	No	If yes, who: _____
Bleeding disorder	Yes	No	If yes, who: _____
Clotting disorder	Yes	No	If yes, who: _____

Children, if applicable. Please list age(s) and sex(es):

Social history:

Job title/employer: _____

Who do you live with? _____

Marital status (circle one): Single Married Divorced Widowed

Do you smoke: Yes No

 If yes: How many packs per day: _____

 Are you willing to quit: Yes No

 Have you tried to quit: Yes No

 What methods: _____

 If no, have you ever smoked: Yes No

 If yes, quit date: _____

Do you drink alcohol: Yes No

 If yes, how many drinks per week: _____

Do you or have you ever used recreational drugs: Yes No

 List type: _____

Do you exercise: Yes No

 If yes, how many days per week: _____

 Type of exercise: _____

New Patient Form

Review of Systems: Please circle symptoms you are experiencing today. If normal, check Normal column.

System	Normal	Abnormal (circle all that apply):
General		Weight loss, weight gain, weakness, fever, fatigue
Skin		Rash, itching, dryness, hair loss, nail changes
Breast		Lump, tenderness, swelling, nipple discharge
Eyes/Ears/Nose/ Throat		Eyes: double vision, tearing, blind spots Ears: pain, discharge, difficulty hearing Nose: bleeding, colds, obstruction, discharge Dental difficulties, gingival bleeding, dentures
Cardiovascular		Chest pain, palpitations, syncope, leg swelling, heart murmur, high blood pressure
Respiratory		Shortness of breath, wheezing, cough, night sweats
Gastrointestinal		Changes in appetite, difficulty swallowing, abdominal pain, heartburn, nausea, vomiting, constipation, diarrhea, changes in bowel habits
Genitourinary		Frequency, urgency, pain with urination, infections, kidney stones, incontinence, retention, vaginal discharge
Musculoskeletal		Joint pain, joint swelling, muscle weakness, muscle cramps, osteoporosis
Neurologic		Seizure, tremor, difficulties with memory or speech, weakness, sensory changes, vertigo, headaches
Psychiatric		Anxiety, depression, hallucinations
Immunologic/ Lymphatic		Food allergy, tape allergy, enlargement of lymph nodes or tenderness, cancer
Endocrine		Heat intolerance, cold intolerance, blood sugar abnormalities, increased thirst, frequent urination
Hematologic		Anemia, bleeding disorder, clotting disorder, transfusion reaction

Patient signature: _____

Date: _____