New Patient Form - Cosmetic

Name: _____ Date of Birth: _____

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: _____
Cardiologist: _____

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? _____
When was your last mammogram? _____

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? _____
Please list age(s) and sex(es) of children:
_____

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
Breast Cancer	Yes	No	HIV	Yes	No

Other, please list: _____
_____

Previous surgeries, please list:

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

Christine Fisher, MD
Board Certified Plastic Surgeon
P. 512.815.0123 | F. 512.861.6206

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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: _____	

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: _____

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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: _____

Office use only:

BP _____

P _____

H _____

W _____

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