
Last Name _____ First _____ MI _____
Mailing Address (Street Name) _____
City _____ State _____ Zip _____
Date of Birth: _____ Age: _____ Sex: ___M___F___ S.S. # _____ Height _____' _____" Weight _____lb
Marital Status S___M___D___W___ Spouse Name: _____
Telephone: Home _____ Cell _____ Work _____
May we leave information on your answering machine or voice mail? ___Y___N May we call you at work? ___Y___N
Email address: _____ May we contact you by email? ___Y___N
How did you hear about our office? _____

Your Occupation: _____ Employer: _____
Employer Address: _____
Emergency Contact Person _____ Relationship _____
Telephone _____ Pharmacy _____

Primary Care Physician _____ Phone _____ Fax _____
Address of Physician _____
City _____ State _____ Zip _____
Referring Physician _____ Phone: _____ Fax: _____
(if other than PCP above) First Last

Name of Primary Insurance _____ Insurance Address _____
Policy Holder's
Name _____ DOB _____ Policy# _____ Group# _____
Secondary Insurance _____ Insurance Address _____
Policy Holder's
Name _____ DOB _____ Policy# _____ Group# _____

I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly to Tarola Plastic Surgery, PLLC. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent.

Name _____ Date of Birth _____

Please list your reasons for this consultation _____

Is this auto or work related? ____ Y ____ N If yes, date of accident _____

PAST MEDICAL HISTORY

Have you ever had or been treated for any of the following: (Please check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Severe ear, nose, throat trouble |
| <input type="checkbox"/> Swelling of ankles or feet | <input type="checkbox"/> Stroke | <input type="checkbox"/> Neuritis |
| <input type="checkbox"/> Cataract/glaucoma | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Double vision/blindness | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Frequent or severe headaches | <input type="checkbox"/> Recent gain/loss of weight | <input type="checkbox"/> Indigestion/GERD/reflux |
| <input type="checkbox"/> Eye injury/disease | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Excessive tiredness/fatigue |
| <input type="checkbox"/> Coughing/vomiting blood | <input type="checkbox"/> Arthritis/joint pain | <input type="checkbox"/> Pacemaker/AICD |
| <input type="checkbox"/> Back problems/pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Chills/fever/night sweats |
| <input type="checkbox"/> Loss of appetite/nausea/vomiting | <input type="checkbox"/> Broken bones/bone disease | <input type="checkbox"/> Chest pain/pressure |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Peptic/stomach ulcer | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Excessive worry/depression | <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Skin rash/disease |
| <input type="checkbox"/> Heart attack/MI | <input type="checkbox"/> Difficulty in sleeping | <input type="checkbox"/> Kidney stone/blood in urine |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Changes in bowel habit/bleeding | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Thyroid problem | <input type="checkbox"/> Bleeding disorder/blood/clot/DVT |
| <input type="checkbox"/> Emphysema/COPD/lung trouble | <input type="checkbox"/> Liver disease/jaundice/hepatitis | <input type="checkbox"/> Aids/ARC |
| <input type="checkbox"/> Weakness/numbness in a limb | <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Epilepsy/seizure disorder |
| <input type="checkbox"/> OTHER(explain below) | | |

Please explain the above if necessary and list any other medical history _____

Have you ever consulted or been treated by a **psychiatrist or psychologist**? ____ Y ____ N

If yes, please explain circumstances _____

Women: Are you, or might you possibly be **pregnant**? ____ YES ____ NO Taking oral contraceptives? ____ Yes ____ No

Number of Term Pregnancies _____ Number of Children Breastfed _____

PAST SURGICAL HISTORY

Please list all prior surgeries, including cosmetic surgeries. _____

Were there any complications? ____ Y ____ N If yes, please list complications: _____

Have you or a family member had any problems with anesthesia? ____ Y ____ N

If yes, please explain circumstances: _____

MEDICATIONS

Do you take **blood thinners**, aspirin or non-steroidal anti-inflammatories (NSAIDs)? ____ YES ____ NO

If yes, please list: _____

Are you allergic to latex? ___Y ___N

Are you allergic to any medications? ___Y ___N If yes, please list:

List all medications you are presently taking including strength and how often:

1. _____ mg _____ times a Day
2. _____ mg _____ times a Day
3. _____ mg _____ times a Day
4. _____ mg _____ times a Day
5. _____ mg _____ times a Day

(For additional medication, please use the back of this form)

Please list ALL vitamins, supplements, and/or herbs you are presently taking: _____

SOCIAL HISTORY

Marital Status Single___ Married___ Divorced___ Widow___

Are you employed Y___ N___ If yes, what is your occupation? _____

Do you live alone? Y___ N___

Are you currently under treatment **for alcohol or drug abuse**? ___YES ___NO

How much alcohol do you consume in one week? ___None ___Light ___Moderate ___Heavy Quit date _____

Do you presently **smoke**? ___YES ___NO If yes, how many packs per day? _____ How long? _____

Have you ever smoked? ___YES ___NO Quit date _____

FAMILY HISTORY

(List any type of cancer or other major illness such as diabetes, heart disease, and etc.)

Mother Alive___ List illnesses _____
Deceased___ List cause of death _____

Father Alive___ List illnesses _____
Deceased___ List cause of death _____

Sister Alive___ List illnesses _____
Deceased___ List cause of death _____

Brother Alive___ List illnesses _____
Deceased___ List cause of death _____

I attest that the above information is complete and accurate.

Patient Signature/Guardian Signature (if under 18)

Date