Palmetto
Cosmetic Surgery and Aesthetics

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NEW PATIENT INTAKE FORM

Today's Date: _____ MGH Unit #_____ DOB:_____ Age:_____

Patient name: _____

Preferred phone number: _____ ☐ **Work** ☐ **Cell**

E-mail address: _____ Occupation: _____

Primary care physician:_____

Address:_____ Phone:_____

Name of person/physician that referred you: _____

Phone: _____ Other: _____

Has your birth mother ever had breast cancer**:** ☐ **Yes** ☐ **No**

Does your birth mother or father have a history of diabetes? ☐ **Yes-Mother** ☐ **No-Mother**

☐ **Unknown-Mother** ☐ **Yes-Father** ☐ **No-Father** ☐ **Unknown-Father**

Does your birth father have a history of heart disease? ☐ **Yes** ☐ **No** ☐ **Unknown**

How tall are you? _____ What is your current weight? _____
(Example: 5 feet, 8 inches)

SMOKING STATUS (cigarettes/tobacco)

Select response:

☐ **I have never smoked** ☐ **I have smoked for ~ years smoked: _____**

☐ **I smoke every day** ☐ **I am a former smoker**

Reason for today's visit: _____

Have you consulted other doctors regarding this problem? □ **Yes** □ **No**

If yes, please list: _____

Have you had any previous surgery for this problem? □ **Yes** □ **No**

If yes, when: _____

PAST MEDICAL HISTORY

General Health: □ Excellent □ Good □ Fair □ Poor
Date of last physical examination: _____

Electrocardiogram performed? □ **Yes** □ **No**
Chest X-Ray? □ **Yes** □ **No**
Are you pregnant? □ **Yes** □ **No**
Do you currently wear a Pacemaker or ICD? □ **Yes** □ **No**
If yes, who is your Cardiologist: _____ Telephone: _____

OTHER CURRENT MEDICAL PROBLEMS (*Please list*): _____

_____

What is your daily or previous consumption of: Coffee/Tea: _____ Tobacco: _____ Alcohol: _____

Do you take Aspirin? □ **Yes** □ **No** Has this been prescribed by anyone? □ **Yes** □ **No**
If yes, by whom and how often do you take: _____

Do you take any: Tylenol, Bufferin, Anacin, Contac, Steroids, Cortisone? □ **Yes** □ **No**
If yes, how often: _____

CURRENT MEDICATIONS (*Please list*)
Include dosages (including birth control pills, diuretics, blood pressure or heart medication, tranquilizers, hormones, blood thinners, sleeping pills or pain medications, over the counter medications, vitamins and herbal supplements)

_____

_____

Do you have any allergies to any medications? □ **Yes** □ **No**
(Please list)

_____

Do you have any other allergies? □ **Yes** □ **No**
(Please list)

_____

Are you now, or have you ever, received psychiatric assistance? □ **Yes** □ **No**

If yes, please list name and address of psychiatrist or psychologist:

_____

_____

PREVIOUS SURGERY (*Please list with dates*)

_____

_____

Have you had complications from previous surgery? □ **Yes** □ **No**
If yes, please describe the complication:

_____

Has anyone in your family had complications from anesthesia? □ **Yes** □ **No**
Do you bruise easily? □ **Yes** □ **No**

PREVIOUS ILLNESSES (*Place an X after any illness you have had*)

Heart murmur___	Rheumatic fever___	Heart attack____
Heart disease___	High blood pressure___	Blood transfusion___
Pneumonia___	Pleurisy___	Emphysema____
Kidney trouble___	Bladder trouble___	Thyroid trouble_____
Hiatal hernia___	Abnormal EKG___	Asthma____
Anemia___	Bleeding disorder____	Jaundice____
Hepatitis___	Ulcer____	Arthritis____
Diabetes___	Phlebitis____	Epilepsy____
Abnormal chest X-ray___	AIDS____	Venereal disease____
Tumor___	Cancer____	Stroke____
Nervous disorder___	Glaucoma____	Albuminuria____
Nerve deficit___	Kidney stones____	Tuberculosis___

Other_____

PRESENT SYMPTOMS (*Place an X after any symptoms you have now*)

Fever/chills___	Excess sweating___	Fatigue____
Vision problem____	Eye pain/redness____	Hearing trouble____
Nose bleeds____	Throat discomfort____	Cough____
Sputum_____	Bloody sputum___	Wheezing____
Chest pains___	Heat intolerance____	Heart skipping____
Shortness of breath___	Swollen feet or ankles____	High blood pressure___
Jaundice____	Heartburn____	Difficulty swallowing___
Abdominal pain____	Nausea/vomiting____	Vomiting blood____
Black stools____	Rectal bleeding____	Diarrhea____
Acid indigestion____	Backache____	Arthritis____
Night time urine____	Bruise easily____	Bleed easily____
Increased thirst____	Increased urine____	Fainting_____
Numbness_____	Tremor____	Muscle_____
Weakness____	Nervousness_____	Depression____

Other: _____