Division of Plastic Surgery

MetroHealth Medical Center

Patient Information Form

PLEASE PRINT

PATIENT NAME_____ BIRTH DATE____/____/____
GENDER M_F_
LAST NAME FIRST NAME MIDDLE

PATIENT
ADDRESS_____
STREET CITY STATE ZIP CODE

PHONE_____ AGE_____ MARITAL STATUS S___M___W___D___ SOCIAL SECURITY #_____-_____-_____

**EMAIL ADDRESS _____

EMERGENCY CONTACT_____ RELATIONSHIP_____
PHONE_____

WHAT TYPE OF WORK DO YOU
PERFORM?_____

EMPLOYER
AND
ADDRESS_____
_____

COMPLAINT (REASON FOR SEEING
US)_____

HOW DID YOU HEAR ABOUT US?
_____

REFERRING
PHYSICIAN_____ADDRESS_____
_

PRIMARY CARE
PHYSICIAN_____ADDRESS_____

Circle the following answers and fill in requested information:

No Yes Do you smoke or use tobacco? How much?_____ How many years?_____
No Yes Do you use nicotine patches or gum?
No Yes Do you regulary drink alcohol or beer? How much?_____
No Yes Do you use marijuana or drugs?

Height _____ Weight _____

Please list medication allergies.

_____

_____
_____

What medications do you take?

_____

_____
_____

Are you presently taking any of the following medications?

No	Yes	Aspirin	No	Yes	Sleeping pills	No	Yes	Barbiturates
No	Yes	Blood pressure pills	No	Yes	Tranquilizers	No	Yes	Phenobarbital
No	Yes	Prednisone	No	Yes	Thyroid medicine	No	Yes	Antibiotics
No	Yes	Cough Medicine	No	Yes	Arthritis medicine	No	Yes	Birth control pills
No	Yes	Digitalis, Digoxin	No	Yes	Headache pills	No	Yes	Alka-seltzer
No	Yes	Hormones	No	Yes	Weight reducing pills	No	Yes	Sinus medicine
No	Yes	Insulin, Diabetic pills	No	Yes	Water pills	No	Yes	Other drugs not listed
No	Yes	Iron pills	No	Yes	Blood thinners			
No	Yes	Laxatives	No	Yes	Dilantin			

PLEASE FILL OUT THE REVERSE SIDE

List any surgeries that you have had.

_____

_____

_____

List your medical problems.

_____

_____

_____

Do you have or have you had any of the following? Circle and explain.

Skin: rash, ulcer, pigment changes,
other_____

Eyes: glaucoma, cataracts, vision problems, eye pain,
other_____

Ears, Nose, Throat: deafness, ringing in ears, deviated septum, sinus trouble,
other_____

Lungs: cough, shortness of breath, asthma, emphysema, COPD, pneumonia, sleep apnea,
other_____

Heart: chest pain, irregular heart beat, heart murmur, heart attack, pain or swelling of lower legs, varicose veins, dizziness, other

_____
Have you had a stress test in the past? If yes, when was the test?_____

Gastrointestinal: nausea/vomiting, heartburn, acid reflux, abdominal pain, ulcer, gallbladder disease, liver disease, jaundice, rectal bleeding or blood in stool, diarrhea, other

_____

Genitourinary: urinary trouble, blood in urine, prostate problems, kidney disease or failure,
other_____

Musculoskeletal: back pain, spine problems, arthritis, muscle pain, joint pain,
other_____

Neurological: headache/migraine, seizures, stroke, passing out, numbness or tingling, tremor, confusion, memory problems, paralysis, other

_____

Psychiatric: mental illness, depression, anxiety, nervous breakdown, eating disorder,
other_____

Blood/Lymph systems: anemia, excessive bleeding, easy bruising, Sickle cell disease or trait, swollen glands, bleeding gums, nosebleeds, other

_____

Endocrine: thyroid problems, goiter, unwanted weight gain or loss, diabetes (sugar), excessive thirst, excessive urination, other_____
_____

WOMEN ONLY THIS SECTION (Circle)

No Yes Have you had or have a blood relative with breast cancer?
No Yes Have you had a breast biopsy? When_____?
No Yes Have you had a mammogram within the last 2 years Result_____.
No Yes Have you ever had a discharge from the nipples of your breasts?
No Yes Are you still having regular menstrual periods? Date of last menstrual period_____.

OFFICE USE ONLY
Height_____ Weight_____ B.P._____ Pulse_____ Resp._____ Temp._____

_____
_____
_____
_____
_____
_____
_____
_____
_____