New Horizons Plastic Surgery LLC

New Patient Health Survey

Please help us learn more about you by providing your health information.

Confidential Information: The information herein will not be released except when you have authorized us to do so. This information will be used by the doctors in their decisions regarding your care.

Date: _____

Patients Name: _____Date of Birth: _____

Who is your Primary Care Doctor? _____

Primary Reason you are here today? _____

How long has this been a problem or concern for you? _____

Have you required any prior treatments or taken medication for this problem / concern?

Explain: _____

Tell us about your Health and Social History:

Medical Illnesses:

_____

Surgeries: (what & when):_____

Medicines you take: _____

Do you have any allergies to any medications?

Family History of: Heart Attacks before age 50. Diabetes, Melanoma, Breast or Ovarian Cancer

Social History: Smoking? _____ How Much: _____ When did you **Quit?!!!** ____

What is your usual Alcohol intake? _____

Recreational Drug Use: _____

Your Support & Family: Do you live with someone who can help you?

Who: _____ How far away do you live? _____

What Kind of work do you usually do? _____

How Often Do You Exercise? _____

REVIEW OF HEALTH SYSTEMS (circle the item if YOU have had any of these)

Have you ever had a problem with anesthesia during or after a procedure?

Have you ever had a psychiatric problem, a nervous breakdown or been under the care of a psychiatrist, psychologist or mental health counselor?

AIDS / HIV, Anemia, Tuberculosis, Hepatitis, Transfusion of blood

Diabetes, Thyroid or Hormone problems

Ear or eye problems, recurrent eye dryness or tearing, Recurrent sinus infections, trouble swallowing, Lumps in your neck.

New Horizons Plastic Surgery LLC

Patient's Name: _____
Asthma, Pneumonia, Recurrent Bronchitis or persistent cough. Frequent shortness of breath which limits your activity.

High Blood Pressure, Stroke, Chest pains, heart problems, palpitations, irregular heartbeat, heart attack, unexplained dizziness or weakness. Blood clots in your legs or lungs. Recurrent leg / foot swelling

Ulcers, Stomach or abdominal surgery, gall bladder or pancreas problems, rectal bleeding, Hernia, recurrent abdominal pain

Kidney problems, blood in your urine, frequent or painful urination, kidney stones, trouble controlling or passing your urine.

Arthritis, Carpal Tunnel syndrome, Hip or Knee problems or surgery, serious neck or back pain or surgery, Nerve damage of any kind, Fractures or serious joint injury

New or changing skin "moles" or growths. Skin cancer, recurrent skin rashes or infection.

Serious accidents or Trauma:

Ladies: When was your last menstrual period _____ Abnormal in any way _____

When was your last mammogram scan?_____

How Many Pregnancies? _____ How Many Children? _____How Old is your youngest? _____

Breast lumps or biopsies, nipple discharge?

Have you unexpectedly "Missed" a period, Could you be pregnant?? _____

Abnormal Vaginal Bleeding, Ovary problems, recent vaginal discharge or pelvic pain.

Your Approximate Weight: _____ Height _____

You've Made It to the End, Thank-you!!!!

Doctors Exam:

Impression:

ICD

Plan:

CPT

Next visit:

Medications:

Time