HEARTLAND PLASTIC SURGERY CENTER

NEW OUTPATIENT VISIT INTAKE FORM

Patient Name _____

Date of Initial Visit _____

ABOUT YOU (Please print clearly.)

Today's date: ____/____/____

Patient: _____
Last First MI

SS#: _____ Sex: Female Male

Age: _____ Birthdate: ____/____/____

Home address: _____
Street

_____
City State Zip Code

Home phone number: _____

Office phone number: _____

Employer: _____

Employer's address: _____

Whom may we thank for sending you? _____

What is their address? _____

Phone number: _____

Marital status: ❒ Single ❒ Married ❒ Div. ❒ Wid. ❒ Sep.

Emergency contact: _____

Relationship: _____

Their home phone number: _____

Their office phone number: _____

Do you have a personal doctor? ❒ Yes ❒ No

Doctor's full name: _____

Their address: _____

Phone number: _____

ABOUT YOUR INSURANCE (Please give the receptionist your insurance card(s) now)

Person responsible for payment (if different than patient)

Name: _____
Last First MI

Social security number: _____

Home address: _____
Street

_____
City State Zip Code

Home phone number:

Office phone number: _____

Employer: _____

Employer's address: _____

Relationship to patient: _____

Primary Medical Insurance

Insurance company: _____

Effective date of coverage: ____/____/____

Co-payment: $_____ Referral required: ❒ Yes ❒ No

Medicare number (if applicable): _____

Secondary Medical Insurance

Insurance company: _____

Effective date of coverage: ____/____/____

ABOUT YOUR HEALTH (Please be sure to complete the back of this form)

Chief Complaint

Please describe the main reason for your visit today:

_____

_____

_____

_____

_____

YOUR SOCIAL HISTORY

Your current employment status: ❒ Retired ❒ Unemployed ❒ Homemaker ❒ Employed

Are you currently married? ❒ No ❒ Yes

How many years of school have you completed? ____

Do you use tobacco? ❒ No ❒ Yes

Is there added stress in your life? ❒ No ❒ Yes

Do you use alcohol? ❒ No ❒ Yes

Do you work in a noisy place? ❒ No ❒ Yes

Do you use caffeine? ❒ No ❒ Yes

Recreational/street drugs? ❒ No ❒ Yes

ABOUT YOUR FAMILY HISTORY

Family History: Indicate Relative		Alive/Cause of death @ age
Cancer	High cholesterol	Mother
Heart	Renal	Father
Diabetes	Psychiatric	Siblings
Stroke/TIA	Thyroid	
High blood pressure	Other	

ABOUT YOUR MEDICAL HISTORY
Have you had any of these problems within the past 18 months?

General			Ear, Nose, Mouth & Throat			Neurologic			Respiratory		
No	Yes	Change in weight	No	Yes	Itchy/waxy year(s)	No	Yes	Migraine headache	No	Yes	Chronic cough
No	Yes	Persistent fever	No	Yes	Draining ear(s)	No	Yes	Facial weakness	No	Yes	Shortness of breath
No	Yes	HIV/AIDS	No	Yes	Ear pain	No	Yes	Facial numbness	No	Yes	Emphysema/asthma
No	Yes	Alcohol/drug abuse	No	Yes	Ear noise	No	Yes	Head injury	Year of last chest x-ray: _____		
No	Yes	Cancer	No	Yes	Hearing loss	No	Yes	Seizures	No	Yes	Blood in sputum
No	Yes	Venereal Disease	No	Yes	Stuffy nose/sinuses	No	Yes	Dizziness or vertigo	**Psychiatric**		
Eyes			No	Yes	Frequent nosebleeds	No	Yes	Stroke	No	Yes	Anxiety
No	Yes	Blurred/double vision	No	Yes	Voice change	**Cardiovascular**			No	Yes	Panic attacks
No	Yes	Glaucoma	No	Yes	Sore throat/mouth	No	Yes	Heart attack	No	Yes	Depression
No	Yes	Eye pain	No	Yes	Lump in neck	No	Yes	Mitral valve prolapse	**Hematology**		
Musculoskeletal			**Gastrointestinal**			No	Yes	High blood pressure	No	Yes	Poor healing
No	Yes	Arthritis	No	Yes	Nausea or vomiting	No	Yes	Heart palpitations	No	Yes	Anemia
No	Yes	Neck stiffness/pain	No	Yes	Colon polyps or	No	Yes	Swelling of feet	No	Yes	Bleeding problems
No	Yes	Swollen joints	No	Yes	Constipation, chronic	**Genitourinary**			**Endocrine**		
Chest			No	Yes	Peptic ulcer	No	Yes	Difficulty in urination	No	Yes	Thyroid problems
No	Yes	Breast tenderness,				No	Yes	Late or absent period	No	Yes	Diabetes
		discharge	**Skin**								
No	Yes	Lump, mass in breast	No	Yes	Rash or eczema	Date of last period: ____/____/____					

MEDICATIONS

Are you currently taking any prescription and/or non-prescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives and cold medications? ☐ No ☐ Yes List medications below:

Name of Medicine	Dose	How Often Taken

Are there other medications you have recently used? ☐ No ☐ Yes
List medications below:

Have you taken aspirin-containing products in the last two weeks? ☐ No ☐ Yes
Have you taken steroid or cortisone-type drugs within the last year? ☐ No ☐ Yes

For Medical Team Use Only:

ALLERGIES

Have you had hives, skin rash, breathing problems or other allergic reactions to medications? ☐ No ☐ Yes List medications below:

Name of Medicine	Describe allergic reaction

For Medical Team Use Only:

Are there medications, other than those you are allergic to you would prefer not to take due to prior unpleasant side effects? ☐ No ☐ Yes

If yes, please specify:

Have you had an allergic reaction to:

Iodine or x-ray contrast dye ☐ No ☐ Yes | Latex or rubber ☐ No ☐ Yes

Bee or wasp stings ☐ No ☐ Yes | Adhesive tape ☐ No ☐ Yes

List any food allergies: ☐ None

Have you ever been hospitalized or had any operations? (Please list reason along with the year of the _____

Operations:		Hospitalizations:	
Reason:	Year:	Reason:	Year:
Reason:	Year:	Reason:	Year:

I, the undersigned, affirm that the information I have given is correct to the best of my knowledge. I authorize treatment of the person named as "patient". I understand that Heartland Plastic Surgery Center will file with my primary insurance company for services rendered and authorize payment of medical insurance benefits directly to Heartland Plastic Surgery Center. I understand that I am responsible for paying any co-payment and deductibles that my insurance does not cover. I authorize Heartland Plastic Surgery Center to obtain or release any information that is related to the treatment of the "patent". A photocopy of this authorization shall be considered as effective and valid as the original document.

Signature _____ Date _____

I have reviewed the above medical information with the patient of their guardian.

_____
Signature of Attending Physician