

PATIENT INFORMATION SHEET

NEW JERSEY PLASTIC SURGERY CENTER, N.J.
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Diplomates of the American Board of Plastic Surgery
Diplomates of the American Board of Surgery

Date of Consultation: _____ Date of Birth _____ Age _____

Patient's Name _____

Home Address _____

City, State, Zip Code _____

Social Security # _____ Marital Status : Married _____ Single _____ Other _____

Home Phone _____ Cell/Other Phone _____

Patient's Occupation _____ Employer _____

Business Address _____ Business Phone _____

Spouse's Name _____ Spouse's Occupation _____

Family Internist _____ Phone _____

Patient Referred By _____

Address _____

Has this office treated any member of your family? _____ If yes, whom? _____

PURPOSE OF INITIAL CONSULTATION

Please check the procedure you are interested in:

- | | | |
|-----------------------------------|--------------------|-----------------------------|
| _____ Liposuction | _____ Brow Lift | _____ Breast Reconstruction |
| _____ Face Lift | _____ Tummy tuck | _____ Breast Reduction |
| _____ Eyelid Surgery | _____ Ear Surgery | _____ Breast Augmentation |
| _____ Rhinoplasty | _____ Gynecomastia | _____ Breast Lift |
| _____ Other, please specify _____ | | |

Have you consulted other Physicians, including Plastic Surgeons, regarding this? _____

If Yes, Physicians Name _____

INJURIES

If consultation is related to an injury, date of injury _____

Injury related to: Work _____ MVA _____ Other _____

Have you been previously treated for this injury? _____

Name of Hospital _____ Name of Physician _____

MEDICAL HISTORY

Height _____ **Weight** _____

Any significant weight loss in the past year? _____ Yes _____ No How Much? _____

Have you ever been pregnant? Yes No How many times? _____
Are you pregnant now? Yes No How many children do you have? _____
When was your last menstrual cycle? _____

ALLERGIES (Please list all including drugs, food, seasonal)

MEDICATIONS (Please list all medications, vitamins, and supplements you are currently taking)

Are there any medications you know you have difficulty tolerating (nausea, upset stomach, etc.)?

When was your last mammogram? _____ Where _____
When was your most recent physical check-up? _____ Physician Name _____
Did it include an electrocardiogram? Yes No Chest X-Ray? Yes No

PLEASE LIST ALL CURRENT MEDICAL PROBLEMS AND THE TREATING PHYSICIANS

PERTINENT PRE-OPERATIVE INFORMATION

Do you smoke? Yes No How much per day? _____
Anyone else in your household smoke? Yes No How much per day? _____
Do you consume alcohol? Yes No How much per week? _____
Caffeine Consumption Coffee Tea How much per day? _____
Other Caffeinated Beverages _____ How much per day? _____

Have you had any illness or disorders of the following?

<input type="checkbox"/> Brain	<input type="checkbox"/> Blood	<input type="checkbox"/> Ears	<input type="checkbox"/> Heart/Blood Vessels
<input type="checkbox"/> Face	<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Liver	<input type="checkbox"/> Reproductive System
<input type="checkbox"/> Lungs	<input type="checkbox"/> Arms/Legs	<input type="checkbox"/> Skin	<input type="checkbox"/> Urinary System
<input type="checkbox"/> Intestines/Bowels	<input type="checkbox"/> Nose/Throat	<input type="checkbox"/> Breast	<input type="checkbox"/> Nervous System

Please Explain _____

Do you have or have you had any significant emotional problems? Yes No
If yes, please explain _____

Have you ever had Psychiatric/Psychological care? _____ Yes _____ No
If yes, please explain _____

Have you ever been diagnosed with Body Dismorphic Disorder? Yes No

PERTINENT PRE-OPERATIVE INFORMATION (Continued)

Have you ever reacted badly to being put to sleep for surgery?..... No ___ Yes ___

Has any member of your family ever reacted badly to being put to sleep for surgery?..... No ___ Yes ___

Have you required unusually large amounts of local anesthetic for medical/dental procedures?.No ___ Yes ___

Have you ever had a reaction to a local anesthetic (Novocaine, etc.)?..... No ___ Yes ___

Are you allergic to adhesive tape? No ___ Yes ___

Are you allergic to latex? No ___ Yes ___

Are you allergic to suture material such as catgut? No ___ Yes ___

Do you have high blood pressure? No ___ Yes ___

Have you ever had scarlet fever or rheumatic fever?..... No ___ Yes ___

Do you bleed unusually easy (from cuts, surgery, tooth extraction)?..... No ___ Yes ___

Do you bruise unusually easily?..... No ___ Yes ___

Are you a slow or poor healer?..... No ___ Yes ___

Do you form large scars or keloids?..... No ___ Yes ___

Do you have skin diseases, hives, eczema, or rash?..... No ___ Yes ___

Do you have frequent infections or boils?.....No ___ Yes ___

Have you taken steroid medications, cortisone, or ACTH?.....No ___ Yes ___

Do you have shortness of breath with walkingNo ___ Yes ___

Do you have or have you had any back trouble?.....No ___ Yes ___

Does your religion prohibit blood transfusions?.....No ___ Yes ___

PREVIOUS SURGERIES/HOSPITALIZATIONS (Please list all)

Date	Surgery/Illness	Hospital & Physician
<hr/>		

Have you had significant complications or after-effects from any of these operations? ___ Yes ___ No

If yes, please explain _____

FAMILY MEDICAL HISTORY

Age	State of Health	Has any relative had:
Mother _____	_____	Tuberculosis..... ___ No ___ Yes
Father _____	_____	Cancer? ___ No ___ Yes
Brother(s) _____	_____	Diabetes? ___ No ___ Yes
Brother(s) _____	_____	Epilepsy? ___ No ___ Yes
Sister(s) _____	_____	Heart Disease? ___ No ___ Yes
Sister(s) _____	_____	High Blood Pressure? ___ No ___ Yes
Children _____	_____	Lung Disease? ___ No ___ Yes
Children _____	_____	Kidney Disease? ___ No ___ Yes
Children _____	_____	Blood or Bleeding Disorder? .. ___ No ___ Yes
		Asthma? ___ No ___ Yes
		Mental Disease? ___ No ___ Yes

EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone _____ Work/ Other Phone _____

INSURANCE – PRIMARY

Primary Insurance Company _____

Claims Address _____

Telephone Number _____

ID # _____ Group Name/ # _____

Subscriber / Insured _____ Subscriber Employer _____

Subscriber Soc Sec# _____ Subscriber Birth Date _____

Relationship of Patient to Subscriber _____

INSURANCE – SECONDARY

Secondary Insurance Company _____

Claims Address _____

Telephone Number _____

ID # _____

Subscriber / Insured _____ Subscriber Employer _____

Subscriber Soc Sec# _____ Subscriber Birth Date _____

Relationship of Patient to Subscriber _____

ASSIGNMENT OF INSURANCE BENEFITS

(To be used only in the event that full payment is not made prior to surgery.)

I, the undersigned, directly assign to NJPS all surgical and/ or medical benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

Patient Signature _____

If patient is under age 18, Signature of Parent/Guardian _____

AUTHORIZE FOR USE OF PHOTOGRAPHS

I authorize the use of any photographs that may be taken of me for teaching, lectures, or illustration in medical publications, for insurance purposes, or to be shown to prospective patients.

Sign

Date

PATIENT NAME: _____ DATE: _____

RIGHT

ST to Nipple -
CL to Nipple -
Nipple to SMF-
CL to SMF-
Vertical Nipple-
Trans Breast -
SMF -
Trans Areola -
Base -
Areola to SMF -
Vertical Areola -
Areola Scar -

COMMENTS

Masses or Lumps
Nipple (I or E)

LEFT

ST to Nipple-
CL to Nipple -
Nipple to SMF-
CL to SMF-
Vertical Nipple -
Trans Breast -
SMF -
Trans Areola -
Base -
Areola to SMF -
Vertical Areola -
Areola Scar -
Height -
Weight -
Bra Size -

COMMENTS

Masses or Lumps
Nipple (I or E)

Estimated Grams
to be Resected
Nipple Discharge

Estimated Grams
to be Resected
Nipple Discharge

