CABBABE PLASTIC SURGERY

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Your Name _____ Your Age _____ Today's Date _____

Referring Doctor: _____ Referring friend (if applicable): _____

Name/phone # of your Primary Care Physician: _____

Please tell us how you heard about us (check all that apply)

- ❑ www.stl-psc.com (our practice website)
- ❑ Google search
- ❑ Realself.com
- ❑ Facebook.com
- ❑ Realpatientratings.com
- ❑ Yellow pages
- ❑ TV
- ❑ Radio
- ❑ Billboard
- ❑ Yellow pages.com
- ❑ Yelp.com
- ❑ Healthgrades.com
- ❑ Vitals.com
- ❑ Ratemds.com
- ❑ Breastimplantsbymentor.com(Mentor website)
- ❑ Itsmyturn.com(Allergan website)

Name/Street/phone# of your pharmacy: _____

Reason for your visit today: _____

Do you have or have you ever had any health problems, which required treatment?(circle Y/N)

Y N Anemia
Y N Bleeding problems
Y N Blood clots
Y N Heart trouble or heart attacks
Y N High blood pressure
Y N Stroke
Y N Paralysis
Y N Lung problems
Y N Emphysema
Y N Thyroid problems
Y N Hepatitis
Y N Gallbladder problems
Y N Kidney trouble
Y N HIV or AIDS
Y N Rectal trouble
Y N Hemorrhoids
Y N Diabetes
Y N Arthritis
Y N Female problems
Y N Breast Cancer
Y N Cancer, Type of cancer: _____
Y N MRSA or other Staph Infections

Please list any prior surgeries:
Surgery (**if applicable, please indicate Left or Right**) Date Physician Hospital

_____
_____
_____
_____
_____
_____

Please list all current medications or provide us with your list so we may photocopy it:
Medicine Dose Frequency

_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have any drug allergies? yes no If yes, check below and list reaction(s):

- ❑ Latex Reaction(s): _____
- ❑ penicillin Reaction(s): _____
- ❑ sulfa Reaction(s): _____
- ❑ "mycin" Reaction(s): _____
- ❑ aspirin Reaction(s): _____
- ❑ codeine Reaction(s): _____
- ❑ tetanus Reaction(s): _____
- ❑ demerol Reaction(s): _____

❑ other medications & reaction(s): _____

Do you smoke currently? no yes
In the past? no yes If yes, how much (per day)?_____

Do you use either of the following products? ___electronic cigarettes ___ chewing tobacco
If yes, how many/how often (per day)? _____

Do you use alcohol currently? no occasionally daily
In the past? no yes

Do you exercise? no occasionally regularly

Do you have any other special needs of which we should be aware? no yes
If yes, please describe? _____

What type of work do you do? _____

Has any blood relative ever had any of the following conditions? If yes, please check below and indicate relationship (i.e. Mother, brother). If applicable please indicate if relative is maternal (mother's side) or paternal (father's side) relative:

- ❑ **NONE**
- ❑ Seizures Relative(s): _____
- ❑ Cancer Relative(s): _____
- ❑ Breast Cancer Relative(s): _____
- ❑ Tuberculosis Relative(s): _____
- ❑ Diabetes Relative(s): _____
- ❑ Heart trouble Relative(s): _____
- ❑ High blood pressure Relative(s): _____
- ❑ Stroke Relative(s): _____
- ❑ Mental illness Relative(s): _____
- ❑ Suicide Relative(s): _____
- ❑ Birth defects Relative(s): _____
- ❑ Kidney troubles Relative(s): _____
- ❑ Kidney stones Relative(s): _____
- ❑ Bladder Relative(s): _____
- ❑ Any heritable disease Relative(s): _____

Have you had pneumonia vaccine? ___No ___Yes Year of last vaccination: _____

Date of last colonoscopy: _____

Females only: Date of your last Pap smear: _____

Females only: Have you had a mammogram? __No __Yes Date of last mammogram: _____

Currently are you experiencing any of the following symptoms? If yes please check below:

- ❑ **NONE**
- ❑ Severe headaches
- ❑ Ringing in the ears
- ❑ Dizziness
- ❑ Fainting spells
- ❑ Blind spells
- ❑ Chest pain
- ❑ Breast pain, discharge or masses
- ❑ Spitting up blood
- ❑ Chronic cough
- ❑ Shortness of breath
- ❑ Fever
- ❑ Severe indigestion
- ❑ Jaundice
- ❑ Diarrhea
- ❑ Rectal bleeding
- ❑ Bleeding tendencies

What is your current height _____ and weight _____

Any recent changes? _____