GLASSMAN PLASTIC SURGERY, PLLC

LAWRENCE S. GLASSMAN, M.D.

HISTORY INTAKE FORM

PATIENT NAME:_____ BIRTHDATE:_____ AGE:_____
SOCIAL SECURITY#_____ PRIMARY CARE DOCTOR:_____
Smoking(type & amount per day)_____ Alcohol(type & amount per week)_____
If former smoker, date quit:_____ Weight:_____ Height: _____
TYPE OF WORK:_____
LIST PREVIOUS SURGERIES OR MAJOR ILLNESS AND DATES: _____
_____
DRUG ALLERGIES(include Reaction): _____
_____
LIST ANY MEDICATIONS (with Doses) you are taking, including non-prescription drugs, vitamins and herbs:
_____
_____
Do you use Aspirin, Ibuprofen (Advil), or any over the counter pain medication regularly?_____
Are you taking Vitamin Supplements? _____ Do you take steroids?_____ Do you use growth hormones?_____
DATE IF LAST TENTANUS SHOT: _____

FAMILY HISTORY:

Has any blood relative ever had the following:

Breast Cancer.....no	yes	High Blood Pressure.....no	yes	Kidney Disease.....no	yes
Melanoma.....no	yes	Heart Disease.....no	yes	Stroke.....no	yes
Diabetes.....no	yes	Deep Vein Thrombosis...no	yes	Malignant Hyperthermia.no	yes
		Pulmonary Embolus.....no	yes		

PERSONAL PAST MEDICAL HISTORY:

Have you ever had the following:

Heart Disease.....no	yes	Cancer.....no	yes	Stomach Ulcer.....no	yes
Chest pain.....no	yes	Arthritis.....no	yes	Glaucoma.....no	yes
Rapid heart beat.....no	yes	Kidney Disease.....no	yes	Dry eyes.....no	yes
Rheumatic Fever...no	yes	Asthma.....no	yes	Thyroid Disease.....no	yes
Anemia.....no	yes	AIDS or HIV+.....no	yes	Bleeding Tendency.....no	yes
Tuberculosis.....no	yes	Stroke.....no	yes	Mitral Valve Prolapse....no	yes
Diabetes.....no	yes	Hepatitis.....no	yes	High Blood Pressure.....no	yes
Skin Rash.....no	yes	Swollen feet/ankles.....no	yes	Seizures.....no	yes
Chronic Diarrhea...no	yes	Swollen lymph nodes.....no	yes	Joint or muscle pain.....no	yes
Chronic cough.....no	yes	Jaundice.....no	yes	Easy bruising.....no	yes
Depression.....no	yes	Deep Vein Thrombosis.....no	yes	Easy bleeding.....no	yes
Weight Change.....no	yes	Pulmonary Embolus.....no	yes	Sleep Apnea.....no	yes
		Malignant Hyperthermia..no	yes		

WOMEN ONLY: (IF APPLICABLE)
Do you take oral birth control pills? _____ Do you use hormone replacement therapy? _____
Age period began:_____ Number of pregnancies:_____
Date of last mammogram:_____ Number of miscarriages:_____
Do you do regular breast self-examination?_____ Breast lump or discharge:_____
Did you breast feed?_____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____ DATE: _____
SIGNATURE OF PATIENT OR PARENT