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