BALLANTYNE PLASTIC SURGERY

Date_____

NAME_____**DOB**_____**M**_____**F**_____**SS#**_____

Address_____**City**_____ **State**_____**Zip**_____

Home Phone_____**Work**_____**Cell**_____

E-Mail Address_____

Reason for consultation?_____**Referred by**_____

Responsible Party if patient is a minor_____

Patient's Employer_____**Address**_____

Occupation_____

Spouse's Name_____**DOB**_____

Spouse's Employer_____**Address**_____

Emergency Contact_____**Phone**_____

Please list the names family members/friends that we may discuss your medical and/or surgical treatment with:_____

May we leave appointment reminders on your answering machine? Y___N___

How did you hear about us?_____

Social History:
Do you smoke? Y__N__ How much_____ Quit_____years ago
Do you use alcohol? Y__N__ How much_____ Caffeine? Y__N__ How much_____
Do you exercise? Y__N__ How often_____

Medical History:
Medication Allergies? Y__N__ If yes, please list_____
_____
Please list medications taken on a regular basis:_____
_____

Do you have, or have you had any of the following:

Heart Disease___ High Blood Pressure___ Diabetes___Stroke/TIA___ Breathing Problems___ MRSA_____
Bleeding Disorders___Arthritis___Headaches___Cancer___GI Problems___Thyroid___
Seizures___Depression___Anxiety Disorder___

Any surgeries?_____
_____
_____
_____
Local, General, or IV sedation?_____

I have answered all the questions concerning my health to the best of my knowledge, and have read and understand the privacy policies of Ballantyne Plastic Surgery. (HIPAA)

Signature_____**Date**_____