Cleveland Plastic Surgery

Dr. Daniel Medalie

Patient Information Form

PLEASE PRINT

PATIENT LEGAL NAME____ BIRTH DATE___/___/___
LAST NAME FIRST NAME MIDDLE

PREFERRED NAME ______________________________ LEGAL GENDER ______________

PREFERRED PRONOUNS ____________________ PREFERRED GENDER ______________

PATIENT ADDRESS____
STREET CITY STATE ZIP CODE

PHONE______________ CELL PHONE ______________ AGE_______ MARITAL STATUS S___M___W___D___

SOCIAL SECURITY #_______-_____-________ RACE____________________

EMAIL ADDRESS ____

EMERGENCY CONTACT____________________ RELATIONSHIP__________ PHONE____________

WHAT TYPE OF WORK DO YOU PERFORM?______________________________________

REASON FOR SEEING US ____

Circle the following answers and fill in requested information:

No Yes Do you have any history of a clotting or bleeding disorder? ________________
No Yes Do you smoke or use tobacco? How much?__________ How many years?________
No Yes Do you use nicotine patches or gum?
No Yes Do you regulary drink alcohol or beer? How much?________
No Yes Do you use marijuana or drugs?
No Yes Do you have any history of sleep apnea?
No Yes Do you snore loudly?
No Yes Do you often feel tired, fatigued or sleepy during daytime?
No Yes Has anyone observed you stop breathing during your sleep?

Height __________ Weight __________

What medications/hormones do you take? ______________________________________

____

List medication allergies. ____

List any surgeries that you have had. ______________________________________

____

List any medical problems. ____

____

ASSIGNED FEMALE AT BIRTH THIS SECTION (Circle)

No Yes Have you had or have a blood relative with breast cancer?
No Yes Have you had a breast biopsy? When________?
No Yes Have you had a mammogram within the last 2 years Result________________________________.

Do you have or have you had any of the following? Please circle and explain.

Skin: rash, ulcer, pigment changes, other____

Eyes: glaucoma, cataracts, vision problems, eye pain, other____

Ears, Nose, Throat: deafness, ringing in ears, deviated septum, sinus trouble, other_____________________________

Lungs: cough, shortness of breath, asthma, emphysema, COPD, pneumonia, sleep apnea, other_________________

Heart: chest pain, irregular heart beat, heart murmur, heart attack, pain or swelling of lower legs, varicose veins, dizziness, other ____
Have you had a stress test in the past? If yes, when was the test?____

Gastrointestinal: nausea/vomiting, heartburn, acid reflux, abdominal pain, ulcer, gallbladder disease, liver disease, jaundice, rectal bleeding or blood in stool, diarrhea, other ____

Genitourinary: urinary trouble, blood in urine, prostate problems, kidney disease or failure, other_________________

Musculoskeletal: back pain, spine problems, arthritis, muscle pain, joint pain, other_______________________________

Neurological: headache/migraine, seizures, stroke, passing out, numbness or tingling, tremor, confusion, memory problems, paralysis, other ____

Psychiatric: mental illness, depression, anxiety, nervous breakdown, eating disorder, other______________________

Blood/Lymph systems: anemia, excessive bleeding, easy bruising, Sickle cell disease or trait, swollen glands, bleeding gums, nosebleeds, other ____

Endocrine: thyroid problems, goiter, unwanted weight gain or loss, diabetes (sugar), excessive thirst, excessive urination, other____

Are you presently taking any of the following medications? (Circle)

No	Yes	Aspirin	No	Yes	Tranquilizers	No	Yes	Antibiotics
No	Yes	Blood pressure pills	No	Yes	Thyroid medicine	No	Yes	Birth control pills
No	Yes	Prednisone	No	Yes	Arthritis medicine	No	Yes	Alka-seltzer
No	Yes	Cough Medicine	No	Yes	Headache pills	No	Yes	Sinus medicine
No	Yes	Digitalis, Digoxin	No	Yes	Weight reducing pills	No	Yes	Other drugs not listed
No	Yes	Hormones	No	Yes	Water pills	____________________________		
No	Yes	Insulin, Diabetic pills	No	Yes	Blood thinners			
No	Yes	Iron pills	No	Yes	Dilantin	____________________________		
No	Yes	Laxatives	No	Yes	Barbiturates			
No	Yes	Sleeping pills	No	Yes	Phenobarbital	____________________________		

Signature: ____Date: _______________________