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 Blood pressure pills
No Yes Prednisone
No Yes Cough Medicine
No Yes Digitalis, Digoxin
No Yes Hormones
No Yes Insulin, Diabetic pills
No Yes Iron pills
No Yes Laxatives
No Yes Sleeping pills

No Yes Tranquilizers
No Yes Thyroid medicine
No Yes Arthritis medicine
No Yes Headache pills
No Yes Weight reducing pills
No Yes Water pills
No Yes Blood thinners
No Yes Dilantin
No Yes Barbiturates
No Yes Phenobarbital

No Yes Antibiotics
No Yes Birth control pills
No Yes Alka-seltzer
No Yes Sinus medicine
No Yes Other drugs not listed
_____
_____
_____

Signature: _____Date: _____