Beaumont
PLASTIC & RECONSTRUCTIVE SURGERY
NEW PATIENT INTAKE FORM

ADULTS

Please fill in all the information as accurately as possible. The information you provide will assist in formulating a complete health profile.

PATIENT INFORMATION

Name_____ Email _____

Address_____ City_____ State _____ Zip _____

Mobile Ph _____ Work Ph_____ Home Ph _____

Date of Birth _____ Legal Sex _____ Height _____ Weight_____

Primary Care Physician _____ Referring Physician_____

Reason for today's Visit: _____

_____

INSURANCE

Primary Insurance_____ Policy # _____

Secondary Insurance _____ Policy # _____

Please let us know if this will be covered under **Workman's Comp** or an **Auto Claim**. If so, please write your Claim Number, Adjustor Name and Adjustor's Phone Number here:

_____

DRUG USAGE / ALLERGIES

Do you use **nicotine products of any kind**? NO _____ YES ____ If Yes, How Often? _____

(Including vaping, gum, patches, hookah, chewing tobacco, cigars and cigarettes)

Do you drink alcoholic beverages? NO _____ YES ____ If Yes, How Often? _____

Do you use any street drugs? NO _____ YES ____ If Yes, How Often? _____

If you have used nicotine products or street drugs within the past year, please write last date of usage:_____

Do you have any **medication allergies**, a **latex allergy** or any other allergies? If so, list all here:

_____

_____

MEDICATION INFORMATION

Are you currently on blood thinners? (i.e. Aspirin, Coumadin, Heparin, Lovenox, Plavix) NO _____ YES _____

Are you taking Tamoxifen or any other Hormone Treatments for Breast Cancer? NO _____ YES _____

Are you taking Oral Contraceptives or Hormonal Supplements? NO _____ YES _____

(please complete other side) ➡

PLEASE LIST ALL **CURRENT MEDICATIONS & SUPPLEMENTS** YOU ARE TAKING:

_____
_____
_____
_____
_____

SURGICAL HISTORY

Have you ever had plastic surgery before? NO _____ YES_____ If yes, please list type and name of surgeon:

_____
_____

Please list all other surgeries you have had:

_____
_____
_____
_____

HEALTH HISTORY

Please check all that apply to you:

[ ] Asthma
[ ] COPD
[ ] Tuberculosis
[ ] High Cholesterol
[ ] High Blood Pressure
[ ] Heart Disease
[ ] Heart Attack(s)
[ ] Heart Stents / Artery Bypass Grafting
[ ] Stroke
[ ] Blood Clots
[ ] Anesthesia Issues
[ ] Anemia / Bleeding
[ ] Thyroid Disorder
[ ] Cleft Lip
[ ] Cleft Palate
[ ] Staph Infection / MRSA
[ ] Hernia
[ ] Skin Disease / Rash
[ ] Scars / Keloids
[ ] Arthritis
[ ] HIV / AIDS
[ ] Sexually Transmitted Disease
[ ] Snoring / Sleep Apnea
[ ] Cancer-Type:_____
[ ] Mental Health Disorder
[ ] Anxiety / Depression
[ ] Diabetes: Type 1 or Type 2
[ ] Kidney Disease
[ ] Urinary Dysfunction
[ ] G.I. Disease
[ ] Auto Immune Disorder
[ ] Seizure Disorder
[ ] Muscular Disorder
[ ] Birth Defects
[ ] Any Other:_____

If you have **family with any of the above health history**, please list them below next to the family relationship:

Father _____ Grandparents_____

Mother_____ Siblings _____

ADDITIONAL IMPORTANT INFORMATION

Do you have any religious, cultural or spiritual beliefs that would prevent you from receiving blood? NO___ YES____

Who lives in your home with you? _____

IF APPLICABLE: Bra Size_____ Date of last Mammogram _____ Number of Pregnancies _____

Number of Miscarriages _____ Number of Living Children _____ Type of Delivery: Vaginal or C-Section