Stephen J. Pincus, M.D., F.A.C.S., Inc.

PATIENT INFORMATION

Date_______________

Home phone_____________

Cell Phone_______________

E-mail____________________

SS#______________________

Name____
Last First Middle

Address____

City___________________________State__________Zip__________

Birthdate______________________Sex_ female_____male______

Married_______Single________Div.__________Minor___________

Patient Employer______________________________________

Employer
Address_____________________________Phone_________________

Occupation____

Whom may we thank for referring you? _______________________

In case of emergency____________________phone_____________

____
Signature of patient, parent or guardian date

____
Please print patient, parent or guardian relationship

STEPHEN J. PINCUS, M.D., F.A.C.S., INC.

COSMETIC AND RECONSTRUCTIVE SURGERY
OF THE FACE, HEAD AND NECK

Patient personal health history

Today's date __ __/__ __/__ __

The information contained herein is confidential and will not be released unless you authorize us to do so. Answer all questions to the best of your knowledge. Please print clearly.

Name ____ Date of birth __ __/__ __/__ __
last first middle

Age ____ Height ____ Weight ____ Sex (circle) M F Marital status (circle) S M W D

PHYSICIAN INFORMATION

Referring physician ____________________________ Address ____

Date of your last physical exam __ __/__ __/__ __

HEALTH HISTORY

Do you have or have you had (circle - if yes, give date of occurrence)

AIDS or HIV	no yes	Congenital heart disease	no yes	Kidney Disease	no yes
Arthritis	no yes	Depression	no yes	Leukemia	no yes
Asthma	no yes	Diabetes	no yes	Migraine	no yes
Back problems	no yes	Dry eye	no yes	Pneumonia	no yes
Bladder infection	no yes	Epilepsy	no yes	Scleroderma/lupus	no yes
Bleeding tendency	no yes	Hay fever	no yes	Stomach ulcers	no yes
Bronchitis	no yes	Heart attack	no yes	Stroke	no yes
Cancer	no yes	Hepatitis	no yes	Thyroid disease	no yes
Colitis	no yes	High blood pressure	no yes	Tuberculosis	no yes

Other serious illnesses which you have had and when ____

____

Serious injuries or accidents and when ____

____

DAILY HABITS

Do you regularly smoke? (circle) no yes If yes, how much? _____

Do you regularly drink 6 or more cups of coffee, cola tea per day? (circle) no yes

Do you regularly drink alcohol? (circle) no yes If yes, how much? _____ glasses/drinks per day

BLEEDING

Do you frequently have bleeding gums, bruising or nose bleeds? (circle) no yes

Have you had blood transfusions? (circle) no yes If yes, when? ______________________________

MEDICATIONS

Which of the following medications do you presently take (check)?

__ Allergy medication	__ Blood pressure pills	__ Diurectics (water pills)	__ Shots
__ Antibiotics	__ Blood-thinning pills	__ Headache pills	__ Sleeping pills
__ Aspirin	__ Cortisone or steroids	__ Hormones	__ Thyroid medicine
__ Arthritis medicine	__ Dietary Aids	__ Insulin or diabetic pills	__ Tranquilizers
__ Barbituates	__ Digitalis	__ Iron-poor blood medicine	__ Weight reducing pills
__ Birth control pills	__ Dilantin	__ Laxatives	__ Other (list below)

Medications (prescription and non-prescription) that you have taken within the last month if not noted above:

1. ____________ 2. ____________ 3. ____________

4. ____________ 5. ____________ 6. ____________

Name any drugs to which you are allergic (including latex):

____

FAMILY HISTORY

Do you know of any blood relative who has or had (check and give relationship):

__ Arthritis	__ Other cancer	__ Heart attack
__ Bleeding tendency	__ Diabetes	__ High blood pressure
__ Breast cancer	__ Epilepsy	__ High fever after surgery

SURGERY HISTORY

List the names and years of any operations or surgeries you have ever had:

____

____

Have you ever had any complications from anesthesia? (circle) no yes

If yes, explain ______________________________

WOMEN ONLY

Is there any chance you may be pregnant? (circle) no yes

Are you still having regular monthly menstrual periods? (circle) no yes

How many pregnancies? __________

Date of last pap smear __ __/__ __/__ __ Results__________

Date of last mammogram __ __/__ __/__ __ Results__________

Note: We recommend regular breast and pelvic exams by your regular physician or gynecologist

MEN ONLY

Is there a discharge from your penis? (circle) no yes

Have you ever had prostate trouble? (circle) no yes

The above information is true to the best of my knowledge.

______________________ ______________________ Date __ __/__ __/__ __

Patient or responsible party's signature Witness' signature