

Cleveland Plastic Surgery

Dr. Daniel Medalie

Patient Information Form

PLEASE PRINT

PATIENT NAME _____ BIRTH DATE ____/____/____
LAST NAME FIRST NAME MIDDLE

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 regularly 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 do you take? _____

List medication allergies. _____

List any surgeries that you have had. _____

List any medical problems. _____

WOMEN ONLY 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: _____