SAN FRANCISCO PLASTIC SURGERY

Karen M. Horton, MD, MSc, FACS, FRCSC
Emily Sespaniak, NP

PLASTIC SURGERY • AESTHETIC SURGERY • NON-SURGICAL AESTHETIC TREATMENTS

PATIENT INFORMATION

Ms./Mrs./Mr./Dr. _____

What name fo you prefer to be called: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Occupation: _____

☐ Single ☐ Married ☐ Divorced ☐ Domestic Partnered ☐ Widowed ☐ Significant Other

Employer: _____ Home #: _____

Work #: _____ Cell #: _____

Which is your primary #: _____ and secondary #: _____

Email address: _____

Who referred you to our practice? _____

BILLING INFORMATION

Primary Insurance Carrier: _____

Policy Holder: _____ Relationship: _____

ID #: _____ Group #: _____

Secondary Insurance Carrier: _____

Policy Holder: _____ Relationship: _____

ID #: _____ Group #: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home #: _____ Work #: _____

What would you like to discuss with the doctor? _____

_____

I hereby authorize the doctors to furnish, to any designated party, all information necessary to file a health insurance claim. I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled by to any health plans, to the doctors. I understand that I am personally responsible for payment of services rendered including major medical

_____ _____

Signature of Insured or Guardian Date

PERSONAL MEDICAL INFORMATION

Patient's Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____

Please answer all questions to the best of your ability. For items that do not apply, write "N/A".

List previous cosmetic and general surgeries and dates: _____

_____

Check all of the following medical conditions that you now have, or have had in the past:

- ☐ Asthma
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Meningitis
- ☐ Hepatitis
- ☐ HIV
- ☐ Bleeding/Bruising Problems
- ☐ Glaucoma
- ☐ Dry Eyes
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Lung Disease
- ☐ Arthritis
- ☐ Anemia
- ☐ Latex Allergy
- ☐ Raynaud's disease/phenomenon
- ☐ Radiation Therapy
  - Where: _____
  - Date ended: _____
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Depression/Anxiety
- ☐ Auto-immune Disease
- ☐ Alcohol/Drug Dependency
- ☐ Irregular Heartbeat
- ☐ Seizure Disorder
- ☐ Eating Disorder
- ☐ Steroid Use
- ☐ Nasal Allergies
- ☐ Herpes/Cold Sores
- ☐ Skin Cancer
- ☐ Other Cancer
- ☐ Sleep Apnea
- ☐ DVT/Blood Clotting disorder
- ☐ Blood Clots
- ☐ Serious Accidents
- ☐ Breast Cancer/BRCA Positive
- ☐ Chemotherapy
  - When: _____

Provide additional information if you have circled any of the above: _____

_____

_____

Do you have any allergies to any medications? Please list: _____

_____

Please list all current medications, herbal supplements & vitamins/dosages:

_____

_____

Tobacco Use/History: _____

Alcohol Use (Drinks/Week): _____

Do you have any family history of breast or ovarian cancer? ☐ YES ☐ NO

Who? _____ What age? _____

Do you have any family history of blood clots/DVT/PE? ☐ YES ☐ NO

Do you have any family history of heart disease? ☐ YES ☐ NO

Do you use ASA/Aspirin?: _____

Do you use Motrin, Aleve, Naprosyn, or any non-steroidal anti-inflammatory medications?

If yes, when was your last use?: _____

_____

What is your exercise routine/How often? _____

_____

When was your last physical examination? _____

Who examined you? _____

Have you or anyone in your family had problems with general anesthesia? If so, please describe: _____

_____

Do you wear: ☐ Contact Lens ☐ Glasses ☐ Hearing Aids ☐ Dentures

WOMEN'S SECTION

Who is your OB/GYN?: _____

Ages of Children, if any: _____

Type of Delivery: _____

Is there any chance you may be pregnant at this time? ☐ YES ☐ NO

What form of birth control/protection do you use?: _____

Date of Last Mammogram: _____ Facility Name: _____

Address: _____ Telephone #: _____

Current bra cup size: _____ Desired bra cup size: _____

Date of last PAP Smear: _____ Where taken: _____

When are you thinking of having this procedure done?:

_____

Is there anything else you think we should know? _____

_____

_____