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PATIENT INFORMATION

Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____
Last First MI

Sex: Male Female Marital Status: M S D W

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ -- Cell Phone: (____) _____ --

E-mail Address: _____

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: (____) _____ --

City: _____ State: _____ Zip: _____

Responsible Party: Myself Other

If other, give name and address: _____

Who referred you to Dr. Hoefflin? _____

Why are you consulting Dr. Hoefflin? _____

What possible surgery do you desire? _____

List any previous plastic surgery (include dates): _____

MEDICAL HISTORY

Please carefully read and answer all questions. Your medical history is very important to the doctor for your proper medical care. This is a confidential record and will not be released without your permission.

Family Physician: _____ Telephone Number: (____) ____-_____

Date of your last complete physical examination: _____

Did it include the following? EKG X-ray Lab Other: _____

Current Height: _____ft. _____in. Weight: _____lbs. Desired Weight: _____lbs.

How much do you smoke per day? _____packs. How much do you drink? _____

Are you allergic to any of the following?

1. Medications: _____

2. Foods: _____

3. Other: _____

Please list any and all medications you are taking:

1. Prescription Medications: _____

2. Non-prescription Medications (including vitamins, aspirins, etc.): _____

Do you have, or have you ever had any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Glasses | <input type="checkbox"/> Easy Fainting |
| <input type="checkbox"/> Chronic Skin Infections | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Sores That Do Not Heal | <input type="checkbox"/> Regular Eye Drop | <input type="checkbox"/> Excessive Anxiety |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Excessive Depression |
| <input type="checkbox"/> Keloids or Bad Scars | <input type="checkbox"/> Visual Difficulty | <input type="checkbox"/> Excessive Fatigue |
| <input type="checkbox"/> Hepatitis/HIV | <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Blood Transfusion/Last 10 Years | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Anemia | <input type="checkbox"/> Eating Problems |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> Difficulty With Anesthesia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Nausea After Surgery |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Herpes or Cold Sores | <input type="checkbox"/> Unexpected Social Status |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Chronic Sore Throat | <input type="checkbox"/> Abnormal Lab Tests: |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Urinary Tract Infections | <input type="checkbox"/> Low Pain Tolerance |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Severe Neck/Back Problems | |
| <input type="checkbox"/> Legs Clots or Embolus | <input type="checkbox"/> Thyroid Problems | |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Rheumatic or Scarlet Fever | |
| <input type="checkbox"/> Poor Leg Circulation | <input type="checkbox"/> Migraine or Headaches | |
| <input type="checkbox"/> Blood Clots In Legs | <input type="checkbox"/> Stomach ulcers or Heartburn | |
| <input type="checkbox"/> Easy Bleeding/Bruising | <input type="checkbox"/> Intestinal Bleeding/Ulcers | |
| | <input type="checkbox"/> Hemorrhoids | |

Are you taking any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Diet Pills | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Aspirin, Motrin, NSAIDS, or Cortisone | <input type="checkbox"/> Metformin, Glucophage, or Insulin |
| <input type="checkbox"/> Blood pressure or Heart Medicine or Water Pill use | <input type="checkbox"/> Herbal Supplements |
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Hormone Supplements |
| <input type="checkbox"/> Other Recreational Drug Use | |

