BAKER
PLASTIC SURGERY

Date _____

Name _____ SSN _____

How you would like to be addressed/Nickname _____

DOB _____ Age _____ Sex _____ Marital Status _____

Significant Other's name _____

Address _____

City _____State _____ Zip _____

Phone #s: Home _____ Cell _____ Bus_____

Email address _____

Local address and number if you are from out of town _____

_____

Occupation _____Employer _____

Employer address _____

Personal physician _____ Phone _____

Ophthalmologist _____ Phone _____

Height _____ Weight _____

Allergies _____

Medications/vitamins/herbal supplements _____

_____

_____

Previous surgeries including Plastic Surgery _____

_____

_____

Do you smoke? _____If yes, how much/often? _____

Did you previously smoke? _____ If yes, when did you quit? _____

Do you drink alcoholic drinks? _____If yes, how often? _____

Do you exercise? _____ If yes, how often? _____

Name of person who referred you _____

Reason for consultation today _____

CONTINUED ON BACK

Review of Systems

Please check yes or no if you have had a history of or experience any of the following:

Eyes, Ears, Nose & Throat	Yes	No
Wear glasses	□	□
Dry eyes	□	□
Glaucoma	□	□
Sinus infections	□	□
Post nasal drip	□	□
Decreased sense of smell	□	□
Difficulty breathing	□	□

Breast		
Personal history of breast cancer	□	□
Family history of breast cancer	□	□
Previous breast surgery	□	□
Lumpectomy	□	□
Cysts/Fibrocystic disease	□	□
Breast pain	□	□
Nipple discharge	□	□
Abnormal mammogram	□	□

Cardiovascular		
Chest pain/Angina	□	□
Heart surgery	□	□
Valve surgery	□	□
Cardiac catheterization	□	□
High blood pressure	□	□
Low blood pressure	□	□
Abnormal EKG	□	□
Heart murmur	□	□
Valve prolapse	□	□

Pulmonary		
Shortness of breath	□	□
Asthma	□	□
Sleep apnea	□	□
Abnormal chest X-ray	□	□

Gastrointestinal		
Heartburn/reflux	□	□
Hiatal hernia	□	□
Ulcers	□	□

Renal		
Kidney disease	□	□
Dialysis	□	□
Recurrent urinary infections	□	□
Diuretics	□	□

Immunological	Yes	No
Lupus	□	□
Scleroderma	□	□
HIV/AIDS	□	□
Arthritis	□	□

Endocrine		
Hyperthyroid	□	□
Hypothyroid	□	□
Diabetes	□	□

Hematological		
Excessive bruising	□	□
Excessive bleeding	□	□
Blood clot	□	□
Hepatitis	□	□
Anemia	□	□

Musculoskeletal		
Fibromyalgia	□	□
Back/neck pain	□	□
Artificial joints	□	□
TMJ	□	□

Gynecologic/Obstetric		
Excessive periods/bleeding	□	□
Menopause	□	□
Hormone replacement	□	□

Oncology		
Personal history of cancer	□	□
Family history of cancer	□	□
Chemotherapy	□	□
Radiation therapy	□	□

Psychological		
Bipolar disorder	□	□
Depression	□	□
Anxiety attacks	□	□
Body dysmorphic syndrome	□	□
Psychiatric Counseling	□	□

Anesthesia		
History of Malignant Hyperthermia	□	□
Relative w/Malignant Hyperthermia	□	□
Adverse reaction to Anesthesia	□	□