John Williams, MD
Plastic Surgery

Patient Information

Confidential Information: The information herein will not be released except when you have authorized us to do so. This information will be used by the doctors in their decisions regarding your care.

Name: _____ Date: _____

Parent or Guardian's Name (for minors): _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Numbers: Home: _____ Cell: _____ Work: _____

Occupation: _____ Employer: _____

E-mail Address: _____ Please check: □ Okay to use □ Do not use

Date of Birth: _____ Age: _____ Weight: _____ Height: _____ □ Female □ Male

Marital Status: □ Single□ Married □ Widowed □ Divorced

Spouse's Name: _____ Number: _____

Emergency Contact Name: _____ Number: _____

Date of last physical exam: _____ Labs: _____ EKG: _____

Primary care physician: _____ Phone: _____

How did you hear about us? _____

What can we help you with today or in the future? _____

Preferred Pharmacy: _____ Address: _____

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Medical History

Your health is of extreme importance to us. The more we know about you, the better we can assist you. Please complete the following information as completely as possible.

Do you have or have you had any of the following? (Please check yes or no)

	YES	NO		YES	NO
AIDS or HIV positive	□	□	Hepatitis	□	□
Anemia	□	□	High blood pressure	□	□
Arthritis	□	□	Irregular heart beat	□	□
Asthma	□	□	Kidney problems	□	□
Back problems	□	□	Migraine headaches	□	□
Blood clots in legs	□	□	Nervous breakdown	□	□
Blood disorders	□	□	Nose/throat problems	□	□
Bleeding problems	□	□	Pneumonia	□	□
Breathing problems	□	□	Psychiatric condition	□	□
Cancer	□	□	Rheumatic Fever	□	□
Chest pains	□	□	Seizures	□	□
Colitis	□	□	Shortness of breath	□	□
Diabetes	□	□	Skin cancer	□	□
Ear/eye problems	□	□	Stomach problems	□	□
Epilepsy	□	□	Stroke	□	□
Heart problems	□	□	Thyroid problems	□	□
Heart murmur	□	□	Tuberculosis	□	□
Heart palpitations	□	□	Transfusion	□	□

Have you had any serious illnesses not listed? _____

List any illnesses that run in your family _____

Do you Smoke? □ Yes □ No If yes, how much and for how long? _____

Do you regularly drink alcohol? □ Yes □ No If yes, how much and how often? _____

List ANY medications, vitamins or herbs taken in the last month _____

_____

List any **allergies** to medications, tape, etc... _____

List all previous surgeries and dates (including cosmetic procedures) _____

_____

Have you ever had any complications following anesthesia? □ Yes □ No

Do you take aspirin or blood thinners on a regular basis? □ Yes □ No

Do you bruise easily? □ Yes □ No

Do you bleed excessively following a tooth extraction? □ Yes □ No

Have you ever had a blood transfusion? □ Yes □ No

Women only: Is there a chance you might be pregnant? □ Yes □ No

HIPAA

Acknowledgment of Receipt of Privacy Notice

I acknowledge that on _____
(Date)

I was provided with a copy of Dr. Williams' **Notice of Privacy Practices,** and

_____ I have read and understand the Notice.

_____ I refuse to sign this acknowledgement.

_____ Patient Representative refuses to sign the acknowledgement.

Comments/Requests: _____

_____

_____

_____

_____

_____

Printed Name of Patient: _____

Patient/Guardian Signature: _____

Patient Coordinator Signature: _____