Piedmont Plastic Surgery, **PA**
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HISTORY FORM

Date: ____________ Name: ______________________________ Date of Birth: ______________

Ht: ______ Weight: ______ lbs. Primary Care and/orMedical Doctor: ______________________

Reason for Visit: ____

List Operations with Dates: ____

____

Any Recent Problems With:

Lungs	☐ YES	☐ NO	Heart	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO	Stroke	☐ YES	☐ NO
Seizures	☐ YES	☐ NO	Cancer	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Urination	☐ YES	☐ NO
Stomach or Intestines	☐ YES	☐ NO	Musculoskeletal	☐ YES	☐ NO
Eyes, Ears, Throat	☐ YES	☐ NO	Enlarged Lymph Nodes	☐ YES	☐ NO
Bleed or Bruise Easily	☐ YES	☐ NO	Skin	☐ YES	☐ NO
Breasts	☐ YES	☐ NO			
Tuberculosis (TB)	☐ YES	☐ NO	Resistant infection (MRSA, VRE)	☐ YES	☐ NO
Have you ever received blood	☐ YES	☐ NO	If so, When? ______________		

Date of last Tetanus Shot: ______________

For Women:

Bra size _____inches _______cup

Number of children ___________

If you answered "YES" to any of the above questions, please provide details:

____

____

____

____

Current Medications (including vitamins and herbs): ______________________________

____

Drug Allergies: ______________________ Circle Reaction: rash, nausea, itching, other __________

______________________ ______________________

Habits: Cigarettes _______ packs/day ______ Alcohol per week: ______________________

If you do not smoke, did you ever? Y N If yes, how many years? _____ Year you quit __________

Have you ever used other (recreational) drugs? Y N

Please list drug use, recreational/substance abuse: ______________________________

List diseases that run in the family: ______________________________

PIEDMONT PLASTIC SURGERY, PA

Notice of Privacy Practices Receipt Acknowledgement

I have been presented with a copy of Piedmont Plastic Surgery's Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice.

______________________________ ______________ ____

Patient Name Date of Birth Signature of Patient or Guardian

Date of Receipt____________________

(1) Please list the family members and/or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment & health care operations):

Name_________________________________ Phone Number____________________

Name_________________________________ Phone Number____________________

Name_________________________________ Phone Number____________________

(2) Please list the family members and/or other persons, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name_________________________________ Phone Number____________________

Name_________________________________ Phone Number____________________

Name_________________________________ Phone Number____________________

(3) Please list the telephone number(s) where you want to receive calls about your appointments, lab & x-ray results, or other health care information:

____________________________________ ____________________________________

(4) Can confidential messages (i.e. appointment information) be left on your answering machine? ___Yes ___No

(5) Can we send you the following information electronically?

Information about your medical conditions _______Yes ________No

Information about health-related benefits or services that may be of interest to you
_______Yes ________No

Information about potential treatment options or alternatives
_______Yes ________No

Appointment reminders _______Yes ________No

Please note that if individuals other than you have access to the contents of this electronic mail address, those individuals could also have access to any information we send to you at that address. Piedmont Plastic Surgery will not be responsible if such individuals access information that is sent to the electronic mail address you provide.

Please note that while we may ask you from time to time if there have been any changes to this information, it is your responsibility to update this information as needed.

Internal Use Only

If patient or patient's representative refuses to sign acknowledgement of receipt of Notice, please document the date and time the Notice was presented to patient and sign below: Presented on (date)______________ Name/Title______________________________

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