# INTAKE FORM

Thank you for visiting Forsyth Plastic Surgery. Please complete the following questionnaire to the best of your knowledge. Doing this as completely as possible will help your physicians care for you.

**NAME**: ________________________________________ **AGE**: ____________

**Which doctor are you seeing today:** ______________________________ **Date**: ______________

**Reason for visit today:**

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**Last:** Weight ________Height_________ **Your Pharmacy (specify location)** ______________________________

**Ethnicity:** ______________________________ **Primary language spoken:** __________________________

**Referring Physician:**_________________________________________________________________

**Primary Care Physician:**______________________________________________________________

**Allergies to Medications:**_____________________________________________________________

**Allergies to other (latex, food, etc.):**___________________________________________________

**Current Medications, Including Dose and Frequency (List):**

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**Past Medical History (circle all that apply):**

| | | | |
|---|---|---|---|
| Anemia | Carpal Tunnel Syndrome | Glaucoma | Musculoskeletal Disorder |
| Anxiety Disorder | Coronary Artery Disease | HIV/AIDS | Neurologic Disorder |
| Arthritis | Dementia | Heart Disease | Osteoporosis |
| Asthma | Dental Problems | Hepatitis | Ovarian Cancer |
| Autoimmune Disease | Depression | High Cholesterol | Pulmonary Embolism |
| Blood Clots | Diabetes | Hypertension | Skin Cancer |
| Body Dysmorphic Disorder | Diverticulitis | Hyperthyroidism | Sleep Apnea |
| Bone or Joint Disease | Dry Eyes | Kidney Disease | Stroke |

| | | | |
|---|---|---|---|
| Breast Cancer | Dupuytrens Disease | Leg Ulcers | Thyroid Disease |
| Breast Disease | Fibromyalgia | Liver Disease | Vascular Disease |
| COPD | GERD/Reflux | Mental Illness | Venous Stasis Disease |
| Cancer | Gastrointestinal Disorders | Metal Implants | |

Other:

**Please list any surgical procedures, including date if known:**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Please list your family medical history, and include relation to you:**

Inherited Diseases:________________________________________________________

Diabetes:_______________________________________________________________

Blood Clotting Disorders:___________________________________________________

Problems with Anesthesia:__________________________________________________

Heart Disease:___________________________________________________________

Lung Disease:___________________________________________________________

Cancer, including Breast Cancer:_____________________________________________

Other:_________________________________________________________________

**Please fill out your social history**

Occupation:_____________________________________________________________

Marital status:___________________________________________________________

Who lives with you at home?________________________________________________

Do you smoke?:__________________________________________________

If so, how much per day?_______________________________________________

If so, for how long?___________________________________________________

Do you drink alcohol?______________________________________________________

If so, how much per day?_______________________________________________

Do you take any illicit drugs?________________________________________________

Is your visit related to a work-related injury?____________________________________

**Please circle if you have any current symptoms or problems with the following:**

**General Health:** Fevers Chills Fatigue Weight Change

| | | | | | |
|---|---|---|---|---|---|
| **Head and Neck:** | Dry Eyes | Visual Changes | Blurred Vision | Eye Irritation | Difficulty Hearing |
| | Ear Pain | Nosebleeds | Nose/Sinus Problems | Sore Throat | Bleeding Gums |
| | Snoring | Dry Mouth | Mouth Ulcers | Teeth Problems | |
| **Cardiovascular:** | Chest Pain | Shortness of Breath | Palpitations | | |
| **Respiratory:** | Wheezing | Coughing | Difficulty Breathing | Sleep Apnea | |
| **Gastrointestinal:** | Abdominal Pain | Nausea | Vomiting | Diarrhea | Change in Appetite |
| | Dark Tarry Stool or Blood | Blood in Stool | | | |
| **Genitourinary:** | Incontinence | Difficulty Urinating | Blood in Urine | Urinary Frequency | |
| **Musculoskeletal:** | Muscle Aches | Muscle Weakness | Arthritis/Joint Pain | Back Pain | Swelling in extremities |
| **Skin:** | Abnormal mole | Abnormal Lesion | Jaundice | Rash | Infection |
| **Neurologic:** | Loss of consciousness | Weakness | Numbness | Seizures | Dizziness |
| | Headaches | | | | |
| **Psychiatric:** | Depression | Sleep disturbances | Alcohol or drug abuse | | |
| **Endocrine:** | Increased thirst | Hair loss | Increased hair growth | Heat intolerance | Cold intolerance |
| **Hematologic:** | Swollen glands | Easy bruising | Excessive bleeding | | |
| **Allergic/Immunologic:** | Runny Nose | Sinus Pressure | Itching | Hives | Sneezing frequently |

*FOR OUR FEMALE PATIENTS*: **Date of last mammogram:** ___________________

**Bra size**: ________________ **No. of pregnancies:** ________________ **Date of last menstruation:** _____________

Thank you for helping us obtain a complete history. Per our policy, all of your medical history will be kept completely confidential.

**Drs. Fagg, Schneider, Kingman & Lawson**
Kim Smith, Office Manager

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