INTAKE FORM

FORSYTH PLASTIC SURGERY

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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