HISTORY/INTAKE FORM

Last Name	First Name	Middle	Date of Birth	SS#	Sex

Primary Care Physician (PCP)	PCP's Phone Number	Date of Last Visit to PCP	Reason for Last Visit to PCP

Referring Physician	Reason for Appointment with Dr. Brantner (Complaint)

IS THIS COMPLAINT RELATED TO : Work Place Injury o Yes o No Auto Accident o Yes o No School Accident o Yes o No Other Accident o Yes o No If "YES" give DATE OF INJURY : ______________

ALLERGIES *(Include drug and/or environmental allergies)*

o ***NO KNOWN***

(If necessary, attach another sheet for either allergies or current medications)

MEDICATIONS YOU ARE CURRENTLY TAKING *(Include Prescriptions, Herbal and Over-the-Counter Medications*

MEDICATION	***DOSAGE (mg)***	***# TIMES DAILY***	***MEDICATION***	***DOSAGE (mg)***	***#TIMES DAILY***

I authorize Plastic & Reconstructive Surgery to download Medication History. Pt Intials: ______

PAST PERSONAL MEDICAL HISTORY: (✓ ***Check if you have had, or now have any of the following problems. A blank indicates NO.***)

o Arthritis
o Asthma
o Back Pain
o Bleeding (Or trouble healing)
o Blood Clots
o Bronchitis (Chronic)
o Diabetes
o Dizziness or Fainting
o Epilepsy
o Headaches
o Heart Disease/Related Problems
o HIV+ or AIDS
o Hypertension
o Kidney Problems
o Mitral Valve Prolapse
o Osteoporosis
o Rheumatic Fever
o Scarlet Fever
o Sleep Apnea
o Stomach Pain or Ulcers
o Stroke
o Thyroid Disease
o Tuberculosis (TB)

o **Cancer** – If Yes, what type(s)? ______________

o **Hepatitis** If YES, what type? ______________ When was it diagnosed? ______________

o Other Health Problems: ______________

o MENTAL HEALTH – List any physician, counselor or facility where you have received treatment or counseling within the last 3 years. ***(If none, write NONE)*** ______________

SURGICAL HISTORY:

Date ________ Surgery ______________ Date ________ Surgery ______________

Date ________ Surgery ______________ Date ________ Surgery ______________

Date ________ Surgery ______________ Date ________ Surgery ______________

FAMILY HISTORY: (✓ *Check if a* ***blood relative*** *has ever been diagnosed with any of the following.* ***A blank indicates NO***)

o Diabetes o Heart Disease o Stroke o Cancer: Who (Mother, Father, etc.) and What Type(s) ______________

SOCIAL HISTORY: o Married o Single o Divorced o Spouse Deceased Number of Children ______ Pregnant Now ______

(✓ *Check any that apply, and explain.* ***A blank indicates NO.***)

o Alcohol What type & how much daily? ______________

o Smoke How Long? ________ How many packs daily? ________ If you have quit, how long ago? ________

o Drug Abuse – *either prescription or street drugs.* If drug abuse is a **resolved problem**, how long have you been drug free? ________
If abuse is a current problem, list all drugs by name. ______________

REVIEW OF SYSTEMS: (✓ *Check if you* ***now have*** *or* ***recently had*** *any of the following:* ***(A blank indicates NO)***)

o Chills and/or Fevers
o Headache
o Nasal Airway Obstruction
o Swollen Glands
o Nausea / Vomiting
o Calf Pain with Walking
o Dizziness/Fainting
o Unusual Sweating
o Fatigue / Trouble Sleeping
o Head Injury
o Sore Throat
o Persistent/Chronic Cough
o Jaundice (Yellow Eyes)
o Leg Cramping
o Numbness
o Confusion
o Unusual Weight _Loss _Gain
o Earache
o Hoarsness
o Chest Pain or Heart Problems (Treated __Yes __No)
o Back/Muscle/Joint Pain
o Seizures
o Depression
o Lesions (New or Changing)
o Loss of Hearing
o Non-Healing Sores
o Shortness of Breath
o Urinary Frequency
o Broken Bone(s)
o Easy Bleeding/Bruising
o Stress
o Rash (New or Changing)
o Visual Impairment
o Lumps
o Diarrhea
o Blood in Urine
o Swelling of Joints
o Excessive Thirst
o Varicose Veins

Women Only: o Abnormal Mammogram (Recent, Reason for this Visit __Yes __No) o Breast Mass/Lump __Right __Left o Breast Pain o Nipple Discharge

Date of Last Mammogram ________ Do you do self-breast exams? __ No __Yes o Monthly o 3 Mths o No Set Schedule o Other ________

Age menstrual periods began ________ Date of Last Menstrual Period ________ Number of Pregnancies ________ Did you breast feed? ________

Patient Signature* ______________ Date ________ Relationship to Patient ________

*** If patient is under 18 years of age, this form must be signed by a parent, legal guardian or person holding Power of Attorney for patient's medical care.

If signature is that of a Legal Guardian or person holding Power of Attorney, we must have a copy of the legal document .