PATIENT INFORMATION

We are pleased to welcome you to our practice. Please take a few moments to completely fill out this form as accurately as possible. All fields are mandatory . If you have questions, we will be happy to help you.

Last Name:	First Name:	Middle Name:	
Street Address:	City & State:	Zip:	Marital Status:
Cell Phone:	Home Phone:	Driver's Lic. #	
( )	( )		

Date of Birth:	Occupation:	Employer:

E-Mail Address:

Preferred Pharmacy for Prescriptions:

Pharmacy Address:

Primary Physician:

Whom may we thank for referring you?

☐ Patient ☐ Physician ☐ Magazine ☐ Hospital ☐ Google ☐ Yelp ☐ Internet

Name of referral:

Emergency Contact:	Relationship to patient & Phone Number
	( )
	Would you like to receive our newsletters?
	☐ YES ☐ NO

Patient Signature: Date:

Health Questionnaire

Date _____/___/_______

Name____________________________________ Referred by______________________________________

Date of Birth___/__/_____ Age_____ Occupation______________________________________

What are you coming in for today?____

Weight:______lbs Height:_______ Current bra size:________ Desired bra size:__________
# of children:______ C-sections: Y or N Did you breast feed?______
**RECENT WEIGHT LOSS: ________lbs Weight at your heaviest: _____lbs

Breast Reductions: Backaches?[ ] Neckaches?[ ] Headaches?[ ] Bra-strap shoulder grooves?[ ] Breast rashes?[ ] Tingling in your arms?[ ] Decreased ability to exercise?[ ]
What have you tried to relieve the above problems?____

List all medications you are taking:
*****Anything you ingest that isn't a food*****

____
____
____
____
____
____
____

Do you take any of the following:

Aspirin/Excedrin...........	Yes[ ]	No[ ]
Ibuprofen/Advil/Motrin…	Yes[ ]	No[ ]
Vitamin E/Multi Vit.............	Yes[ ]	No[ ]
Herbal Remedies..........	Yes[ ]	No[ ]
Tylenol/Acetaminophen.	Yes[ ]	No[ ]
Green Tea………..	Yes[ ]	No[ ]
Fish oil/Omegas/Flax seed	Yes[ ]	No[ ]

List all hospitalizations, operations (including plastic surgery, biopsies or childhood surgeries) **and serious injuries:**

Year	Surgery-Hospitalization-Injury
_______	______________________________
_______	______________________________
_______	______________________________
_______	______________________________
_______	______________________________

ALLERGIES:

	yes	no	effect
Penicillin.................	[ ]	[ ]	_________
Latex........................	[ ]	[ ]	_________
Other antibiotics…….	[ ]	[ ]	_________
Iodine......................	[ ]	[ ]	_________

Nausea/vomit w/ pain meds? Y or N

Illness & Medical Problems

	Yes	No
Anemia……………	[ ]	[ ]
High Blood pressure..	[ ]	[ ]
Bleed/Bruise Easily....	[ ]	[ ]
Constipation…………	[ ]	[ ]
Bleeding disorder.......	[ ]	[ ]
Heart Attack.............	[ ]	[ ]
Heart murmur............	[ ]	[ ]
Autoimmune disorder	[ ]	[ ]
Diabetes................	[ ]	[ ]
Trouble with anesthesia	[ ]	[ ]
Arthritis.................	[ ]	[ ]
Anxiety disorder........	[ ]	[ ]

	Yes	No
Ulcer......................	[ ]	[ ]
Bowel problems........	[ ]	[ ]
Headaches ……….....	[ ]	[ ]
DVT/Pulmonary Embolus	[ ]	[ ]
Hepatitis.................	[ ]	[ ]
Convulsions/seizures..	[ ]	[ ]
Asthma...................	[ ]	[ ]
Rheumatologic disorder	[ ]	[ ]
Emphysema.............	[ ]	[ ]
Pneumonia/bronchitis...	[ ]	[ ]
Dry eyes.............	[ ]	[ ]

Women only:

Breast biopsies?.....Y or N

Last Mammogram date ________

Results ____________________

History of breast cancer? Y or N

Family History (mom, dad, brother, sister)

	Yes	No
Blood Disorders.....	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
Diabetes...............	[ ]	[ ]
DVT/Pulmonary embolus...	[ ]	[ ]
Cancer..................	[ ]	[ ]
Breast Disease…..	[ ]	[ ]

Social History

1) Marital Status [ ]Married [ ]Single [ ]Sig. other [ ] Widowed
2) Use of Drugs? [ ] Never [ ] Type & freq__________
3) Use Alcohol? [ ] Never [ ] Occasional [ ] Daily
4) Use Tobacco/Nicotine Products?

[ ] Never [ ]Not Now [ ] Yes, currently

packs per day______ # of Years? ________

Signature of Patient or Guardian X________________________________ Reviewed by_________________