MEDICAL HISTORY & INTAKE FORM

Patient Full Name: _____

Today's Date:

Please indicate the reason for your visit:

- ☐ Lacerations, Cuts or Burns
- ☐ Abscess - Incision & Drainage
- ☐ Animal Bites or Scratches
- ☐ Foreign Object Removal
- ☐ Other - please specify:

When did this occur?

Select One:

- ☐ Today
- ☐ Yesterday
- ☐ Within the past week
- ☐ More than a week ago - please specify:

Do you have any special concerns/needs regarding your visit in order for us to take better care of you?

PAST MEDICAL HISTORY

Please indicate if you have any of the following conditions:

- [ ] Epilepsy or Seizures
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] Mitral Valve Prolapse
- [ ] Cancer
- [ ] Anemia
- [ ] Peptic Ulcer Disease
- [ ] Glaucoma
- [ ] Diabetes
- [ ] Bleeding Tendency
- [ ] Blood Clots
- [ ] Stroke
- [ ] Asthma
- [ ] Hepatitis
- [ ] Depression
- [ ] Anxiety
- [ ] Kidney Disease
- [ ] Arthritis
- [ ] Thyroid Disease
- [ ] Tuberculosis
- [ ] Cold Sores or Fever Blisters
- [ ] Frequent Heartburn/ Reflux
- [ ] Sleep Apnea
- [ ] Blood Transfusion
- [ ] Positive for HIV

- [ ] Currently PREGNANT or BREAST-FEEDING
- [ ] Other:
- [ ] NONE OF THESE APPLY TO ME

ALLERGIES

(please include tape, latex, local anesthetics, seasonal irritants and their effects):

- [ ] NO KNOWN ALLERGIES

If you have allergies, please list below:

HEIGHT:

WEIGHT:

SURGICAL HISTORY

(Include Cosmetic)

- [ ] NONE

If you have had any surgeries, please list TYPE and DATE below:

MEDICATIONS

(include non-prescriptions, vitamins and herbal supplements)

- [ ] NONE

If you take any medications or supplements, please list below:

PAST SOCIAL HISTORY

NICOTINE USE

Please indicate if any of the following apply to you:

☐ I am a non-smoker and do not use any products containing nicotine (write N/A in all boxes below)

Current Smoker or other nicotine use - Please specify type and amount of nicotine used below (includes vapes, e-cigs, cigars, cigarettes, chewing tobacco, etc):

How long have you been using Nicotine?

I am a former smoker - Please indicate quit date below:

ALCOHOL USE

Please specify how often you consume alcohol:

- ☐ I never drink alcohol
- ☐ Seldomly, <1 drink per month
- ☐ Socially, <4 drinks per month
- ☐ Weekly
- ☐ Daily

Please specify type of alcohol:

In the past year, have you used any illegal drugs or prescriptions for non-medical reasons?

- ☐ No
- ☐ Yes - please specify below:

Have you traveled out of the country within the past 4 weeks?

- ☐ No
- ☐ Yes - please specify location below:

FAMILY HISTORY

Has ANY RELATIVE ever had the following:

- [ ] Breast cancer
- [ ] High Blood Pressure
- [ ] Kidney Disease
- [ ] Melanoma
- [ ] Heart Disease
- [ ] Depression
- [ ] Stroke
- [ ] Diabetes
- [ ] Blood clots (legs or lungs)

REVIEW OF SYSTEMS

Please indicate if you CURRENTLY have or HAVE had any of the following conditions within the LAST 6 MONTHS:

- [ ] Fever
- [ ] Weight loss
- [ ] Swollen lymph nodes
- [ ] Dry Eyes
- [ ] Vision Changes
- [ ] Joint Pain
- [ ] Muscle Pain
- [ ] Abdominal Pain
- [ ] Difficulty breathing
- [ ] Allergies
- [ ] Chronic cough
- [ ] Chest pain
- [ ] Rapid heart beat
- [ ] Dizziness

- [ ] Swollen feet/ankles
- [ ] Numbness
- [ ] Tingling
- [ ] Painful urination
- [ ] Bloody urine
- [ ] Easy bruising
- [ ] Easy bleeding
- [ ] Skin rashes
- [ ] Keloids
- [ ] Depression

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature:

You have the option to sign this Agreement electronically or sign a paper copy of this Agreement. By signing electronically using any device, means or action, you consent to the legally binding terms and conditions of this Agreement. You further agree that your signature on this Agreement (hereafter referred to as your 'E-Signature') is as valid as if you signed this Agreement in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting agreement between you and CARE Plastic Surgery, PC. You are also confirming that you are authorized to enter into this Agreement in your behalf. You understand that by selecting the 'Decline' button you have the option to have this Agreement made available to you in paper form for hand signing.

You acknowledge that you have access to an account with an internet service provider, and you are able to view or download a copy of the this Agreement by accessing your secure TouchMD account at https://patient.touchmd.com/ (requires the latest web browser), or by using the myTouchMD app (requires the latest iOS or Android version). You understand that a paper copy of this Agreement can also be obtained by contacting CARE Plastic Surgery, PC at info@careplasticsurgery.com or by calling 919-484-4884.