STEIN PLASTIC SURGERY

Patient Intake Sheet
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name ______________________ .
First Middle Last

Address ______________________
Street & Apt # City State Zip

Home Phone ____________ Cell Phone ____________ Business Phone ____________

Any restrictions for contacting you? ❒ No ❒ Yes E-mail ____________

Contact Restrictions: ____________

Age ______ Birthdate / / ____________

Marital Status ❒ Single ❒ Married to: ____________ ❒ Other: ____________

Patient's Employer ____________ Occupation ____________

Work Phone ____________ Ext: ______ Is it okay to call you at work? ❒ Yes ❒ No

Address ______________________
Street & Suite # City State Zip

If you were referred by a specific person, may we thank them? ❒ Yes ❒ No

Emergency Contact
(Not in your household) ____________ Relationship to Patient ____________

Home Phone ____________ Work Phone ____________ Other Phone ____________

Areas that may interest you:*

- ❒ Blepharoplasty (Eyelid Lift)
- ❒ Botox
- ❒ Brow or Forehead Lift
- ❒ Facial Implants (Cheek/Chin)
- ❒ Facial Liposuction (Neck, Jowls)
- ❒ Face or Neck Lift
- ❒ Lip Enhancement
- ❒ Otoplasty (Ear Pinning)
- ❒ Rhinoplasty (Nose Reshaping)
- ❒ Skin Resurfacing (Laser, Peel, Etc.)
- ❒ Wrinkle Fillers (Injections)

How did you hear about Dr. Stein?

❒ TV News ❒ TV Ad ❒ LocateADoc ❒ Magazine ❒ Newsletter ❒ Seminar ❒ Salon ❒ Web

❒ Friend/Relative: ____________ ❒ Doctor:

If you were referred by a specific person, may we thank them? ❒ Yes ❒ No

Pursuant to HIPAA, I acknowledge that I have received a copy of this office's notice of Privacy.

Signature: ______________________ Date: ______________________

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STEIN PLASTIC SURGERY

(919) 261-7099

4301 Lake Boone Trail, Suite 309, Raleigh, NC 27607

Health Information as of ________________ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

DO YOU NOW OR HAVE YOU EVER HAD……….. (You must circle an answer for each individual item)

Heart Trouble	Yes	No
Heart Attack	Yes	No
Chest Pain	Yes	No
Palpitation or Irregular Pulse	Yes	No
Stroke	Yes	No
Hypertension	Yes	No
Blood Pressure Abnormalities	Yes	No
Abnormal EKG	Yes	No
Shortness of Breath	Yes	No
Chest Pain	Yes	No
Asthma	Yes	No
Pneumonia	Yes	No
Tuberculosis	Yes	No
Smokers Cough	Yes	No
Emphysema	Yes	No
Coughing or Spitting of Blood	Yes	No
Major Allergies	Yes	No
Palsy or Paralysis	Yes	No
Drug Habit	Yes	No
Psychiatric Hospitalization or Care	Yes	No
Thyroid Problems	Yes	No
Kidney or Renal Disease	Yes	No
Chemotherapy or Radiation Treatments	Yes	No
Acutane Treatment for your skin	Yes	No
Fever Blister (s)	Yes	No
Any part of your body been paralyzed	Yes	No
Are you easily upset or irritated	Yes	No
Do you often feel unhappy or get depressed	Yes	No

Glaucoma or Eye Problems	Yes	No
Visual Disturbances	Yes	No
Loss of Vision	Yes	No
Hepatitis	Yes	No
Cirrhosis of the Liver	Yes	No
Alcoholism or Drug Dependency	Yes	No
Esophageal Varices	Yes	No
Ulcers	Yes	No
Diabetes	Yes	No
Skin Disorders	Yes	No
Arthritis	Yes	No
Bleeding Tendency or Disorder	Yes	No
Airway Obstruction (Nasal)	Yes	No
Breast Cysts, Tumors, Abscesses	Yes	No
Nipple Discharge (Apart from Normal Lactation)	Yes	No
Seizures or convulsions or fainting spells	Yes	No
Black outs	Yes	No
Any family members with bleeding problems	Yes	No
Any family members with anesthesia problems	Yes	No
Heart Murmur	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No
Missed or irregular last menstrual period	Yes	No
Family history of cancer, heart trouble, stroke	Yes	No
Allergic to latex or latex products	Yes	No
Local Anestesia (Novocaine or Xylocaine)	Yes	No
By Dentist or Doctor?		
Did you have any "reaction to it"?	Yes	No
Autoimmune disorder	Yes	No

If you answered "yes" to any of these questions, please explain here:

MEDICAL HISTORY, CON'T

Please list all present medications, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Include over-the-counter medications.**

____

____

____

1. Do you have an allergic reaction to any medication? ☐ Yes ☐ No Which? ______________

2. Do you react abnormally to any medication? ☐ Yes ☐ No Which? ______________

3. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?

   ☐ Yes ☐ No If yes, when and where? ______________

4. Have you ever been on cortisone or steroid treatment? ☐ Yes ☐ No When? ______________

5. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?

   ☐ Yes ☐ No If so, how much? ______________

6. Do you smoke? ☐ Yes ☐ No If so, how much? ______________ For how long? ______________

7. Are you pregnant? ☐ Yes ☐ No When was you last normal menstrual period? ______________

8. How many pregnancies? __________ Births? __________ Breast Fed? ☐ Yes ☐ No How long? __________

   CHILDREN (list names and ages/birthdays): ______________

   ____

9. Is there anything else you think the doctor should know? ______________

   ____

10. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:

    SURGICAL OPERATIONS (include where, when and why for each surgery): ______________

    ____

    ____

    HOSPITALIZATIONS (include where, when and why for each admission): ______________

    ____

By signing below, I agreee that the above information is complete and accurate to the best of my knowledge.

Signature: ______________________________ Date: ______________

Amy .