Advanced Plastic Surgery, PC
4551 Cascade Rd SE Suite D
Grand Rapids, MI 49546
Phone 616.323.3102 Fax 616.323.3061

Patient Information

Patient Name: _____ Preferred Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____

DOB & Age: _____ Race: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Sex: _____ SSN: _____ Email Address: _____

Employer Name: _____

Occupation: _____ Work Phone: _____

Primary Care Physician: _____

How did you hear about our clinic?

☐ Dr. Referral: _____
☐ Patient Referral: _____ ☐ Google
☐ Friend: _____ ☐ Other:_____

Preferred Pharmacy:_____

What is the nature of your visit? _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other:

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance

Name: _____ Policy #: _____ Group ID: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Date of Birth:_____

Secondary Insurance

Name: _____ Policy #: _____ Group ID: _____

Policy Holder's Date of Birth:_____

Section I: Surgery and Anesthesia History

1. Have you ever had surgery? ☐ No ☐ Yes, please describe:

_____

_____

2. Have you or any of your blood relative had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

_____

_____

Section II: Specific Medical History

Height:_____ Weight:_____lbs Are you pregnant? ☐ No ☐ Yes ☐ N/A

	Have you, or do you still have:	No	Yes	Description
1.	Asthma	☐	☐	
2.	Emphysema	☐	☐	
3.	High Blood Pressure	☐	☐	
4.	Heart Trouble (stents, heart attack, arrhythmia)	☐	☐	
5.	Hepatitis or Liver Trouble	☐	☐	
6.	Kidney Trouble	☐	☐	
7.	Diabetes	☐	☐	
8.	Epilepsy or Seizures	☐	☐	
9.	Stroke	☐	☐	
10.	Problem Scarring	☐	☐	
11.	Have you been advised to or had psychiatric care?	☐	☐	
12.	Others Not Listed:			

Section III: Social History

1. Do you smoke?
   ☐ No, never ☐ No, but former smoker, quit _____ years, days, months ago
   ☐ Yes, current smoker, how much? _____
2. Do you drink? ☐ No ☐ Yes, how much? _____
3. Do you have children? ☐ No ☐ Yes, how many? _____

Section IV: Family History

	Have any blood relatives had any of the following?	No	Yes	Description
1.	Cancer	☐	☐	
2.	Bleeding Tendency	☐	☐	
3.	Leukemia	☐	☐	
4.	Heart Disease	☐	☐	
5.	High Blood Pressure	☐	☐	
6.	Repeated Infections	☐	☐	
7.	Chronic Lung Disease	☐	☐	
8.	Tuberculosis	☐	☐	
9.	Asthma	☐	☐	
10.	Severe Allergies	☐	☐	
11.	Kidney Disease	☐	☐	
12.	Arthritis	☐	☐	
13.	Mental Illness	☐	☐	
14.	Convulsions or Fits	☐	☐	
15.	Migraine Headaches	☐	☐	
16.	Diabetes	☐	☐	
17.	Gout	☐	☐	
18.	Thyroid Trouble	☐	☐	
19.	Obesity	☐	☐	

Section V: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:

Section VI: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

Section VII: Review of Systems

In the past six months, have you experienced any of the following?

Constitutional	Yes	No	Comments
Chills	☐	☐	
Sweating	☐	☐	
Fatigue	☐	☐	
Fever	☐	☐	
Lethargy	☐	☐	
Sleep difficulties	☐	☐	
Weight loss	☐	☐	
Weight gain	☐	☐	
Other	☐		
Eyes			
Blindness	☐	☐	
Cataracts	☐	☐	
Diabetic retinopathy	☐	☐	
Glaucoma	☐	☐	
Glasses/Contacts	☐	☐	
Blurred Vision	☐	☐	
Other	☐		
Ears/Nose/Throat/Neck			
Ringing in the Ear(s)	☐	☐	
Hearing aids	☐	☐	
Hearing loss	☐	☐	
Frequent nose bleeds	☐	☐	
Nasal congestion	☐	☐	
Dental pain	☐	☐	
Bleeding gums	☐	☐	
Dentures/partials	☐	☐	
Difficulty swallowing	☐	☐	
Hoarseness	☐	☐	
Jaw pain	☐	☐	
Sore throat	☐	☐	
Other	☐		
Cardiovascular			
Heart murmur	☐	☐	
Chest pain/pressure	☐	☐	
Palpitations	☐	☐	
Other	☐		
Respiratory			
Use Oxygen/BiPap/CPap	☐	☐	
Productive sputum	☐	☐	
Chest congestion	☐	☐	
Cough	☐	☐	
Cough up blood	☐	☐	
Shortness of breath	☐	☐	
Snoring	☐	☐	
Wheezing	☐	☐	
Other	☐		
	☐		

Gastrointestinal	Yes	No	Comments
Colon polyps	☐	☐	
Hemorrhoids	☐	☐	
Liver problems	☐	☐	
Heart burn/Indigestion	☐	☐	
Abdominal pain	☐	☐	
Constipation	☐	☐	
Diarrhea	☐	☐	
Jaundice	☐	☐	
Dark/tarry stools	☐	☐	
Nausea	☐	☐	
Vomiting	☐	☐	
GU/Nephrology			
No/low urine	☐	☐	
Blood in urine	☐	☐	
Night urination	☐	☐	
Urinary frequency	☐	☐	
Menopausal Symptom	☐	☐	
Pregnancy	☐	☐	
Prostate Problems	☐	☐	
Recurrent UTI	☐	☐	
Full bladder/hesitant	☐	☐	
Leaky bladder	☐	☐	
Dermatologic			
Rash	☐	☐	
Bruising	☐	☐	
Skin Lesions	☐	☐	
Stretch marks	☐	☐	
Neurologic			
Numbness/tingling	☐	☐	
Abnormal walk	☐	☐	
Speech trouble/aphasia	☐	☐	
Frequent Headaches	☐	☐	
Memory loss	☐	☐	
Seizure	☐	☐	
Tremors	☐	☐	
Passing out	☐	☐	
Dizziness	☐	☐	
Psychiatric			
Depression	☐	☐	
Anxiety	☐	☐	
Other	☐		
Hematologic/Lymphatic			
Bleed/bruise easily	☐	☐	
Blood transfusion(s)	☐	☐	
Anemia	☐	☐	
Blood clots in veins	☐	☐	
Other	☐		

Musckuloskeletal

Joint stiffness	☐	☐	_____
Pain	☐	☐	_____
Joint swelling	☐	☐	_____
Muscle weakness	☐	☐	_____
Back pain	☐	☐	_____
Postural back pain	☐	☐	_____
Neck/shoulder pain	☐	☐	_____
Grooving in shoulders	☐	☐	_____
Breast pain	☐	☐	_____
Other	☐		_____

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature:_____ Date:_____

Consent to Communicate

Patient Name:

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appt Reminders				
☐ Email Medical Info				
☐ Email Marketing Info				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Page	-	-	☐	-
☐ Text Appt Reminders – if so, list cell carrier:				
☐ Text Marketing Info – if so, list cell carrier:				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____