Name_____

Please explain your concerns briefly:

_____
_____
_____
_____

If your visit concerns a **HAND** problem, are you ____right or ____left handed?

*For **FEMALE PATIENTS,** please indicate:*

Last menstrual period _____ Hysterectomy? ___YES ___NO
Menopause? __YES __NO
Number of pregnancies _____ Number of live births _____ Ages of living children _____
Did you breast feed? ____YES ___NO Do you plan any further pregnancies? ___YES ___NO

If you are considering Breast Surgery:
Current Bra Size_____ Largest Bra you have ever worn_____ Desired cup size _____
Last breast exam_____ Last mammogram_____ Normal_____ Abnormal____
Do you have any breast lumps? ___YES ___NO
Do you have any nipple discharge? ___YES ___NO

Past Medical History:
Have you ever received treatment for the following? **Please check all that apply:**

___Hepatitis, Jaundice, Cirrhosis, or Liver Disease
___Asthma, TB, Pneumonia, or Emphysema
___Heart Attack, Angina, Palpitations, Irregular Heart
___Shortness of Breath or Fainting Spells
___Abnormal or Excessive Breathing
___Rheumatic Fever or Congenital Heart Disease
___Kidney Failure, Kidney or Prostate Problems
___Migraines, Headaches, or Chronic Head Pain
___Shingles, Cold Sores, Fever Blisters, Oral Herpes
___Abnormal Healing or Poor Scar Formation
___Anxiety, Depression, Psychological or Emotional Problems
___Nervous Breakdown or Personality Disorder
___Phlebitis, Blood Clots, or Varicose Veins
___Stomach ulcer
___Blood Transfusion
___HIV or AIDS
___Chronic Cough
___High Blood Pressure
___Low Blood Pressure
___Hives, Rash, Skin Disease
___Diabetes, Abnormal Blood Sugar
___Thyroid Problems
___Edema or Persistent Swelling
___Anemia or Blood Disorders
___Autoimmune Disease
___X-ray Treatment or Radiation

Do you have any other conditions not listed above?
_____

Do you currently use: ___eyeglasses ___contacts ___hearing aids ___dentures
What is your current weight? _____
What is the most you have ever weighed? _____
How much would you like to weigh? _____

Are you experiencing or have you experienced any of the following?

Constitutional Symptoms

___Unexplained weight gain/loss
___Fever or chills
___Night sweats/hot flashes
___Loss of appetite

Hematologic/Lymphatic

___Bleeding or bruising

Eyes

___Blurred or double vision

Ear/Nose/Mouth/Throat

___Hearing loss or ringing
___Earaches or drainage
___Chronic sinus problems
___Recurrent nose bleeds
___Bleeding gums
___Sore throat or voice change
___Hay Fever
___Sore/loose teeth, cavities

Cardiovascular

___Heart Trouble
___Chest Pain or Angina
___Palpitations (Fast or irregular beats)
___Shortness of breath while walking
___Shortness of breath while lying flat
___High Blood Pressure
___Swelling in feet or ankles

Respiratory

___Chronic or frequent cough
___Coughing up blood
___Shortness of breath
___Asthma or wheezing

Gastrointestinal

___Change in bowel movements
___Nausea and vomiting
___Frequent diarrhea
___Painful bowel movements
___Frequent constipation
___Rectal bleeding or blood in stools

___Abdominal pain
___Heartburn
___Trouble swallowing

Genitourinary

___Frequent urination
___Burning or painful urination
___Blood in urine
___Urination more than once at night
___Incontinence or dribbling
___Decrease in urine stream
___Sexual difficulty
___Slow to start/stop urination
___Female: irregular periods

Musculoskeletal

___Joint pain
___Joint stiffness or swelling
___Neck pain
___Back pain/low back pain

Skin/Breast

___Rash/itching
___Breast pain
___Breast lump
___Breast discharge

Neurological

___Frequent or recent headaches
___Light headed or dizzy
___Convulsions or seizures
___Numbness or tingling sensations
___Paralysis
___Memory loss or confusion

Endocrine

___Thyroid disease
___Diabetes

Past Surgical History

No previous surgeries

Please list previous surgeries and dates. Be sure to include any cosmetic surgery, permanent dental work such as veneers, bridges, crowns or retainers

_____

_____

MEDICATIONS: Please list all medications you are currently taking:

Medication Dose/Strength Frequency

_____

_____

_____

Are you currently or have you in the past taken:

Cortisone Prednisone Steroids Accutane

Are you allergic to any medications?

_____

Are you allergic to anything else?

_____

Are you taking any over the counter medication? (Please include Vitamins, Minerals, Supplements, Herbals or Diet Pills)

_____

Social History

Sex: M___ F___

____Single ____Married ____Divorced ____Widowed ____Other

Number of Children: ____ Ages: _____

Use of Alcohol: Never Rarely Moderate Daily

Use of Tobacco: Never Previously Currently (Packs per day) _____

Are you currently working? Yes No Retired

What is your current occupation? _____

Family Medical History: Please check if your immediate family members have the following? (Please indicate the relationship)

Arthritis_____

High Blood Pressure_____

Asthma_____

Allergies_____

Mental Problems_____

Bleeding Tendencies_____

Reaction to Anesthesia_____

Cancer_____

Stroke_____

Breast Cancer_____

Melanoma_____

Tuberculosis_____

Diabetes_____

Genetic Disorder_____

DVT/Blood_____

Pulmonary Embolism_____

Heart Disease_____

Obesity_____

Third Party Access Form

Patient Name_____ Date of Birth___/___/_____
Patient
Address_____
Chart #_____Social Security
#_____

I AUTHORIZE THE RELEASE OF MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING:

Name_____Name_____
Address_____Address_____
Phone#_____ Phone#_____
Relation to Pt _____ Relation to Pt_____

If any of these individuals contact us, they will be asked to provide your social security number. Please make sure they know this information. Anyone who is not named above or who cannot provide your social security number will be denied access to your **Protected Health Information.**

*****I understand information disclosed pursuant to this authorization may be re-disclosed to additional parties and is no longer protected.

*I understand I may revoke this authorization at any time by signing the revocation section of this form and returning it to the address above. I further understand any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

*I understand I am under no obligation to sign this authorization. I further understand my treatment will not depend in any way on whether or not I sign this authorization.

*I understand I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

*I understand the clinic named above will not receive compensation for the uses and disclosures I have authorized.

NOTE: After the initial completion of this form, any additions or deletions must be given to healthcare provider in writing.

NAME_____DATE_____
SIGNATURE_____

Revocation Section

I hereby revoke this authorization_____
Date_____

Revocation received by the clinic_____
Date_____

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have received a copy of the clinic's **NOTICE OF PRIVACY PRACTICE.**

_____Date_____
Signature of Patient or Legal Guardian

If not signed by the patient, please indicate relationship:

_____Parent or guardian of minor patient
_____Guardian or conservator of an incompetent patient
_____Beneficiary or personal representative of deceased patient

I would like to receive a copy of any amended **NOTICE OF PRIVACY**
____YES ____NO

For Office Use Only

____Signed form received by:
____Acknowledgement refused:
Efforts to Obtain: _____
Reason for refusal: _____

Patient's date of birth: ____/____/____
Patient's chart number: _____

Please Bring Insurance Cards to All Appointments

Patient Name _____Sex: M____ F____

Mailing Address_____

City_____State_____Zip_____

Home Phone Work _____Cell_____

Date of Birth___/_____/_____Age_____SS#_____

Marital Status Single _____Married _____Widowed _____Other_____

Primary Insurance_____

Policy Holder/Name on Card_____
ID#_____Group#_____

Secondary Insurance_____

Policy Holder/Name on Card_____

Patients Employer_____

Spouse or Parents Name_____

Nearest Relative/Friend **NOT** living with you_____
Phone_____

Preferred Pharmacy_____
Primary Care Physician_____

Email Address_____

Were you referred to our office by another physician? Yes _____No_____

If so, by who? _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN
_____DATE_____

St. Bernards PLASTIC SURGERY

Informed Consent for Medical Photography and Marketing

I (print name) _____ hereby authorize Dr. Jaeger, as well as any assistants he may designate, to take photographs of me (including digital images) for diagnostic purposes and to enhance medical records. I agree that these images will remain the property of St. Bernards Plastic Surgery and that I will request to obtain a copy of these images if needed. I understand that these photos are vital for diagnosis and treatment.

I consent for my photographs to be utilized for lectures, continuing medical education, scientific papers, patient education, patient information booklets, as well as "Before and After" displays on our website.

I give St. Bernards permission to contact me regarding potential marketing efforts.

***Patient Signature* _____*Date*_____**

***Witness Signature* _____*Date*_____**