



DEPARTMENT OF PLASTIC SURGERY
 GEORGETOWN UNIVERSITY HOSPITAL
 3800 RESERVOIR ROAD, NW
 1ST FL. PHC BLDG
 WASHINGTON, DC 20007
 202-444-8751

We have recently transitioned to electronic medical records for our office. The accuracy of your demographic and pertinent chart summary data is critical. Please help us to ensure our information is current by taking a few moments to provide the following information. Please return this form to the front desk personnel when complete. We appreciate your assistance.

PATIENT DEMOGRAPHICS			
NAME: First		Last:	MI:
Date of Birth:		Home #:	
Cell #:		Work #:	
Address:			
City, State, Zip			

PHYSICIAN INFORMATION			
Primary Physician:		Phone #:	
Address:		Fax #:	
Referring Physician:		Phone #:	
Address:		Fax #:	

PHARMACY INFORMATION			
Pharmacy Name:		Phone #:	Fax #:
Address:			

MEDICATIONS			
<input type="checkbox"/> No Current Medications		Aspirin: <input type="checkbox"/> Yes <input type="checkbox"/> No	Ibuprofen: <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Please list medications you are currently taking (include prescriptions, over the counter medications, vitamins, and herbals); please include approx. start dates and dosage of each medication if known.</i>			
1.	Start date: Dosage:	5.	Start date: Dosage:
2.	Start date: Dosage:	6.	Start date: Dosage:
3.	Start date: Dosage:	7.	Start date: Dosage:
4.	Start date: Dosage:	8.	Start date: Dosage:

**** Please let the receptionist know if you have more than 8 medications.**

ALLERGIES			
<input type="checkbox"/> No Known Drug Allergies			
1.	2.	3.	4.

CURRENT HEALTH PROBLEMS: ** If you are currently taking medication for a specific medical problem, please indicate the medical problem below.

MEDICAL HISTORY: Please check medical conditions you have had in the past and for which you are no longer taking medication. If you listed the condition above in "Current Health Problems," you do not need to check it here.

<input type="checkbox"/>	Alcohol / Drug Abuse	<input type="checkbox"/>	Deep Vein Thrombosis	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Sjogren's Disease
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	Skin Cancer
<input type="checkbox"/>	Anesthesia Problem	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	GERD	<input type="checkbox"/>	Neurologic Disease	<input type="checkbox"/>	TIA
<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	Unremarkable
<input type="checkbox"/>	Bleeding Tendency	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Other Cancer	<input type="checkbox"/>	Use of Steroids
<input type="checkbox"/>	Breast Cancer	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Paraplegia/Quadraplegia	<input type="checkbox"/>	Venous Stasis
<input type="checkbox"/>	Central Venous Access	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Pulmonary Embolism	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	Circulation probl/PAD	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Raynaud's Disease	<input type="checkbox"/>	Cirrhosis
<input type="checkbox"/>	Clotting Tendency	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Scleroderma	<input type="checkbox"/>	Crohn's Disease
<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Hypotension				
		<input type="checkbox"/>	Seizure Disorder				
OTHER:		1.		2.		3.	
		4.		5.		6.	

PAST SURGICAL HISTORY: (Please check all that apply):

<input type="checkbox"/> NO PAST SURGICAL HISTORY							
<input type="checkbox"/>	Abdominal Surgery	<input type="checkbox"/>	CABG	<input type="checkbox"/>	Hernia Repair	<input type="checkbox"/>	Otoplasty
<input type="checkbox"/>	Abdominoplasty	<input type="checkbox"/>	Cesarean Section	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	Rhinoplasty
<input type="checkbox"/>	Adenoidectomy	<input type="checkbox"/>	Cleft Lip Repair	<input type="checkbox"/>	Jaw Surgery	<input type="checkbox"/>	Septoplasty
<input type="checkbox"/>	Alveolar Bone Graft	<input type="checkbox"/>	Cleft Palate Repair	<input type="checkbox"/>	Lap Band Surgery	<input type="checkbox"/>	Thyroidectomy
<input type="checkbox"/>	Amputation	<input type="checkbox"/>	Cosmetic Surgery	<input type="checkbox"/>	Liposuction	<input type="checkbox"/>	Tonsillectomy
<input type="checkbox"/>	Appendectomy	<input type="checkbox"/>	Face Lift	<input type="checkbox"/>	Lumpectomy	<input type="checkbox"/>	Tubal Ligation
<input type="checkbox"/>	Blepharoplasty	<input type="checkbox"/>	Facial Surgery	<input type="checkbox"/>	Mastectomy (Lt/Rt)	<input type="checkbox"/>	Vision Corr Surgery
<input type="checkbox"/>	Breast Augmentation	<input type="checkbox"/>	Flap Surgery	<input type="checkbox"/>	MOHS Surgery	<input type="checkbox"/>	Wisdom Tooth Removal
<input type="checkbox"/>	Breast Biopsy	<input type="checkbox"/>	Fracture Repair	<input type="checkbox"/>	Neck Lift	<input type="checkbox"/>	Breast Lift/Mastopexy
<input type="checkbox"/>	Gallbladder	<input type="checkbox"/>	Nerve Surgery	<input type="checkbox"/>	Breast Recon	<input type="checkbox"/>	Gastric Bypass Surgery
<input type="checkbox"/>	Hx of Anesthesia Comp	<input type="checkbox"/>	Breast Reduction	<input type="checkbox"/>	Genioplasty	<input type="checkbox"/>	Hx of Surgical Comp
<input type="checkbox"/>	Brow Lift	<input type="checkbox"/>	GYN Surgery				
OTHER:		1.		2.		3.	

FAMILY HISTORY: (Please check all that apply):

<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Breast Cancer
<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Bleeding Tendency	<input type="checkbox"/>	Other Cancer	<input type="checkbox"/>	Peripheral Neuropathy
OTHER:		1.		2.		3.	

SOCIAL HISTORY: (Please check all that apply):

Marital Status:		# of Children:	
Occupation:		Education:	
Smoking Status:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Packs/Day: #	Quit Date:
Alcohol:	<input type="checkbox"/> None <input type="checkbox"/> Rare <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently		

I have reviewed and/or updated the above information and confirmed it is accurate.

Patient Signature: _____ Date: _____