Bergman Folkers Plastic Reconstructive & Hand Surgery

Patient Medical History

Name:____ Date:__________

How were you referred to us today?

By another physician (name)______________________________

Phone Book Newspaper Radio TV Friend Other________________

Allergies:____

Are you allergic or sensitive to latex, balloons, rubber, etc? Yes No Last tetanus?__________

Family physician:____

Why are we seeing you today?____________________________________

Were you seen in the emergency room? Yes No If yes When ?________________

Were X-rays or any other test taken for this injury? Yes No

If yes,explain:____________________________________

Do you take medications for any reason (prescription and/or over the counter)? Yes No

If so please list them:____________________________________

Are you a current smoker? Yes No If yes amount per day:________________

Do you have a history of smoking? Yes No If yes amount per day, how long and your quit date?

Do you drink alcohol? Yes No Amount per day?________ For how long?________

Do you or have you ever used narcotics? Yes No If yes, please explain:____________

Have you ever had any of the conditions listed below? If yes, please give details.

Condition	Yes	No	Details
Anemia	Yes	No	
Asthma/Hayfever/Allergies	Yes	No	
Blurred/ Double Vision . . .	Yes	No	
Cardiac Problems	Yes	No	
Chest Pain	Yes	No	
Chronic Cough	Yes	No	
Colitis/ Bowel Disease	Yes	No	
Diabetes	Yes	No	
Ear/Nose/Throat Problems .	Yes	No	
Gallbladder Disease	Yes	No	
Heart Murmur	Yes	No	
Hepatitis/Yellow Jaundice . .	Yes	No	
HIV/AIDS	Yes	No	
Hypertension.	Yes	No	
Kidney Disorder	Yes	No	
Pneumonia	Yes	No	
Polio/Meningitis	Yes	No	
Psychiatric Disorder	Yes	No	
Rheumatic Fever	Yes	No	
Seizure Disorder	Yes	No	
Tuberculosis	Yes	No	
Unconscious/Fainting Spells	Yes	No	

Have you ever been pregnant? Yes No

If yes, number of: vaginal deliveries________ c- sections_____ miscarriages________ abortions______

Have you ever had surgery before? Yes No

If yes, Please list names of all surgeries:________________________________

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____

Have you ever had a general anesthetic? Yes No

If yes, any adverse reactions?________________________________

Have you ever had a blood transfusion? Yes No If yes, date:________________

FAMILY HISTORY:

Cancer . . . . Yes No________________________________

Diabetes . . . . Yes No________________________________

Epilepsy . . . . Yes No________________________________

Heart Disease . . . . Yes No________________________________

High Blood Pressure . . Yes No________________________________

Is there any other significant history that we should be aware of? Yes No If yes, explain:________________

____

To the best of my knowledge, the medical information supplied is accurate and complete.

Signature of Patient or Parent/Legal Guardian:________________________ Date:________

This Section to be completed by physician or nurse

B/P Height: Weight:

HEENT:

Cardiovascular:

Respiratory:

Gastrointestinal:

Urogenital:

Extremities:

Neurological:

Physician's Signature:________________________ Date:__________

Nurse's Signature:________________________ Date:__________

Receipt of Notice of Privacy Practices

Acknowledgment of Receipt of Notice of Privacy Practices

I would like to request the following restrictions on the uses and disclosures of my protected health information. Please place a check mark on the applicable line.

___I do not wish to be contacted about reminder appointments by phone.

___I do not wish to be contacted about reminder appointments by mail.

___I do not wish to be contacted about future open houses for cosmetic procedures and/or products.

If the above restricted information is needed to provide me with emergency treatment, or cancellation of an appointment due to an emergency on the part of Bergman & Folkers Plastic/ Reconstructive & Hand Surgery, you may suspend the above agreement.

____
Name of Patient or Personal Representative (Printed)

____
Signature of Patient or Personal Representative

____
Date

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My Signature on this form Indicates that I have received a Notice of Privacy Practices. If you have any questions, please contact our Privacy Officer at 515-222-1111

____
Name of Patient or Personal Representative (Printed)

____
Signature of Patient or Personal Representative

____
Date
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