Date _____

Name _____ Date of Birth

_____

Address _____ Apt #

_____

City_____ State _____ Zip Code

_____

Home # _____Cell #

_____

Email Address __

Gender: Male Female

Primary Care Dr. _____ Phone#

_____

Cardiologist: _____ Phone#

_____

How did you hear about us?

_____

I request communication of my Protected Health Information from Lee Plastic Surgery and Medical Spa Via:
***Preferred Method of Communication*: TEXT EMAIL PHONE CALL**
(Voicemail No Yes)

Emergency Contact Information

Name _____ Relationship

_____

Home # _____ Cell #

Pharmacy Information

Name_____ Phone Number #

_____

Location

_____

MEDICAL/SURGICAL HISTORY INFORMATION

Name _____ Date of Birth _____ Date _____

Reason for Visit Today?

_____

List all previous surgeries and hospitalizations

_____.

_____.

_____.

_____.

Are you allergic to any medications ( ) NO ( ) YES

If YES, please list the medications:

_____

_____

List ALL medications you are taking including over the counter medications, herbs, vitamins, teas, diet pills and dietary supplements:

Medication	Dosage	How Often

Check any of the following which you have or have had:

□ **Artificial Joints/Implants**	□ **High/Low Blood Pressure**	□ **Psychiatric Condition**
□ **Asthma**	□ **Heart Murmur**	□ **Chemotherapy**
□ **Blood clots/Bleeding**	□ **Hepatitis**	□ **Stroke**

□ **Breast Cancer**	□ **HIV**	□ **Thyroid Disorder**
□ **Other Cancer**	□ **Infections**	□ **Tuberculosis**
□ **Chest Pain**	□ **Kidney Problems**	□ **Other**
□ **Chemical/Radiation Therapy**	□ **Liver Disease**	
□ **Defibrillator**	□ **Malignant Hyperthermia**	
□ **Diabetes**	□ **MRSA**	
□ **Eye Problems**	□ **Neurologic Disease**	
□ **Heart Disease**	□ **Pacemaker**	

FAMILY HISTORY: list immediate family members either deceased (with cause of death and age) or living with serious illness:

_____

_____

_____

_____

_____

_____

Are you Currently Pregnant or Lactating? No Yes

SOCIAL HISTORY: Please check and answer all the following questions:

Yes No

( ) ( ) Do you have any skin problems? If yes, please describe:

Rash_____ Bleeding_____ Bruising

( ) ( ) Do you smoke? If yes, how much per day?

_____

( ) ( ) **Are you a former smoker? If yes, when did you stop?**
_____

( ) ( ) **Do you drink alcoholic beverages? If yes, how much per day?**
_____

( ) ( ) **Do you have vision problems? If yes, please explain:**
_____

( ) ( ) **Do you wear eyeglasses?**

( ) ( ) **Do you wear contact lenses?**

( ) ( ) **Do you wear removable denture appliance/denture?**

( ) ( ) **Do you now or have ever used "street drugs"?**

( ) ( ) **Do you wear hearing aids?**

( ) ( ) **Do you have breathing problems?**

If yes, please explain:
_____

( ) ( ) **Do you have a cough? If yes, please describe: ( ) Moist ( ) Dry ( ) Hacking**

( ) ( ) **Are you on a special diet? If yes, please explain:**
_____

( ) ( ) **Do you have any disease, condition or problem not listed that you think Dr. Lee should know about?**

If yes, please explain: _____

Initials_____

Notice of Receipt of Privacy Practice

I hereby acknowledge that I received a copy of the Notice of Privacy Practice for Lee Plastic

Surgery & Medical Spa, S. Darrell Lee M.D. and if I have any questions, I will notify the staff.

_____

Patient Name (Please Print)

_____ _____

Patient Signature **Date**