STEPHEN LOBER
PLASTIC SURGERY PC

ASPS Member Surgeons®

PATIENT INFORMATION

Patient Name _____
DOB _____
Age _____
Height _____
Weight _____

Family Physicians _____
Referring Source _____
Date of Last Physical Exam _____
Cardiologist Name/Phone # _____
Pharmacy Name/Phone # _____

Reason For Today's Visit: _____

CURRENT OR PREVIOUS ILLNESS/INJURIES (dates):

_____ ( )
_____ ( )
_____ ( )
_____ ( )
_____ ( )

PREVIOUS OPERATIONS (dates):

_____ ( )
_____ ( )
_____ ( )
_____ ( )
_____ ( )

DO YOU (circle one):

Smoke Y N _____ per day
Drink Alcohol Y N _____ per day
Drink Coffee Y N _____ per day

PAIN MANAGEMENT

Are You Enrolled in Pain Management?

Y N (circle one) Name of Doctor _____
Telephone _____

ALLERGIES? _____

Do You Have a Latex Allergy? (circle one) Y N

CURRENT MEDICATIONS: (vitamins, supplements)

HAVE YOU EVER EXPERIENCED (circle one):

Frequent Nose Bleeds?	Y N
Bleeding Gums?	Y N
Bled Excessively From Tooth Extractions?	Y N
Bled Excessively From Laceration?	Y N
Do You Take Aspirin Regularly	Y N

MEDICAL HISTORY	Yourself	Your Family
Arthritis	Y N	Y N
Asthma	Y N	Y N
Bleeding Tendency	Y N	Y N
Bronchitis	Y N	Y N
Cancer	Y N	Y N
Skin Cancer	Y N	Y N
Diabetes	Y N	Y N
Epilepsy	Y N	Y N
Hay Fever	Y N	Y N
Heart Problems	Y N	Y N
Hepatitis	Y N	Y N
High Blood Pressure	Y N	Y N
Kidney Disease	Y N	Y N
Migraines	Y N	Y N
MRSA	Y N	Y N
Nervous Breakdown	Y N	Y N
Pneumonia	Y N	Y N
Stomach Ulcers	Y N	Y N
Stroke	Y N	Y N
Thyroid Problems	Y N	Y N
Tuberculosis	Y N	Y N
OTHER _____	Y N	Y N

I understand that outside medical personnel may review my medical records for the purposes of Quality Assurance and State License.

Patient's Signature _____ ___/___/___