ARTISTRY.SCIENCE.COMPASSION

MELLUL EYE & FACIAL PLASTIC SURGERY, PC

PATIENT DEMOGRAPHIC INFORMATION:

PATIENT NAME:_____DATE: _____

DATE OF BIRTH:_____ AGE:_____GENDER:_____

ADDRESS: _____ _____

CITY: _____ STATE: _____ZIPCODE:_____

PHONE NUMBER: home:_____mobile:_____EMAIL: _____
BEST WAY TO REACH YOU: Home: ☐ Mobile: ☐ Email: ☐

SOCIAL SECURITY #:_____
MARITAL STATUS: _____ EMPLOYMENT STATUS: _____
FAMILY PHYSICIAN/CONTACT INFO: _____
PHARMACY: Address:_____ Phone: _____
OCCUPATION:_____

Whom may we thank for this referral*(how did you find us)?*_____

INSURANCE:
Primary Insurance Company: _____
Subscriber: _____ DOB of subscriber :_____
Relationship to Patient: _____
Policy #:_____ Group #: _____

Secondary Insurance: _____
Subscriber: _____ DOB of subscriber :_____
Relationship to Patient:_____
Policy #:_____ Group #: _____
Preauthorization #:_____

By signing below you agree to to receive pertinent information about your appointment & medical related questions. You also agree that you or your representative completed this information dutifully.
*SIGNATURE:*_____

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PATIENT HEALTH QUESTIONNAIRE:

WHAT IS THE REASON FOR YOUR VISIT TODAY?:_____

MEDICAL HISTORY (please check if you have, had any of the following):

Diabetes (high blood sugar)	☐	High Blood Pressure	☐	heart attack/ heart disease	☐	irregular heartbeat	☐
Lung Disease/COPD	☐	ulcers/G.I. bleed	☐	Gerd/reflux	☐	stroke	☐
muscle weak/fatigue/twitch	☐	lower back	☐	Cholesterol	☐	blood clots/DVT	☐
recent sickness/ flu	☐	HIV	☐	kidney problems/dialysis	☐	skin disorders	☐
Hepatitis/liver disease	☐	herpes/fever blister	☐	dry eyes/vision problems	☐	anemia/bleediing	☐
Lupus/RA/autoimmune dx	☐	history of cancer	☐	history of skin cancer	☐	Snoring	☐

OTHER PERTINENT MEDICAL HISTORY:_____

FAMILY HISTORY: _____

SURGICAL HISTORY (please list any and all surgeries you have had):

_____ _____

MEDICATION LIST(please list any current medications you take):

1._____ 2. _____ 3. _____

4._____ 5._____ 6._____

7. _____ 8._____ 9._____

Do you take? Fish Oils☐Vitamin E☐Garlic in heavy doses☐ Wine daily☐ Advil ☐

DO YOU SMOKE?: YES☐ **NO** ☐ IF SO : how many packs ____ **Have you smoked in Past?__**

ALLERGIES TO Medicines: (IF You Have Allergies to Medicines please list them here)**:**

_____

Please place a Check mark next to the symptoms that most appropriately matches the way you feel:

REVIEW OF SYSTEMS:

SKIN:	abnormal scarring	____	rashes/scaling	____	lumps	____	itching	____	color changes	____
GEN:	weight change	____	appetite change	____	strength	____	exercise	____	fever/chills	____
HEAD:	head injury	____	headaches	____	neck injury	____				
EYES:	vision loss	____	redness	____	tearing	____	dryness	____	pain	____
	double vision	____	Flashing light	____	floaters	____	glaucoma	____	glasses	____
EARS:	change in hearing	____	tinnitus	____	bleeding	____	vertigo	____	balance	____
NOSE:	nose bleeds	____	stuffiness	____	sinus pain	____	discharge	____		
MOUTH:	dental difficulties	____	gum bleeding	____	dentures	____				
NECK:	hoarseness	____	stiffness	____	neck pain	____	tender	____	neck mass	____
RESPIR:	shortness of breath	____	wheezing	____	cough	____	sputum	____		
HEART:	chest pains	____	palpitations	____	pacer	____	defibril	____	short breath	____
GI (Gast):	abdominal pains	____	bowel habit	____	constipa	____	nausea	____	diarrhea	____
GU:	urinary urgency	____	frequency ch.	____	burning	____	pain	____		
VASC:	calf pain walking	____	leg cramps	____						
JOINT/MUSCLE:	joint pain	____	pain in muscles	____	limited range of motion	____			back pain	____
NEURO:	weakness	____	tremor	____	seizures	____	memory loss	____		
PSYCH:	depression	____	anxiety	____	hallucinate	____	personality/mood disorders			____
HEMATO:	bleeding tendency	____	nosebleeds	____	transfusion	____				
ENDOCRINE:	weight changes	____	heat intolerant	____	excess sweat	____	loss of hair	____	cold intoleran	____
GYN:	change menses	____	pelvic pain	____	history/STD	____				