



**HISTORY & PHYSICAL:**

*Dr. Eyssen Dr. vonWerssowetz Dr. Chase*

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Reason for Seeing Dr. \_\_\_\_\_

Primary Care Dr \_\_\_\_\_ Referring Dr or Person \_\_\_\_\_

Medications: Include over-the-counter meds & herbs \_\_\_\_\_

Drugs or Other Allergies: (List) \_\_\_\_\_

Previous surgery and/or hospitalizations: (List) \_\_\_\_\_

<b>PAST MEDICAL HISTORY</b> (Check Box)	Yes	No
Heart Disease/Hypertension		
Bleeding Tendency/Blood Clots		
Asthma/Bronchitis/Tuberculosis		
Cancer. If so, where? _____		
Diabetes		
Depression/Mental Disorder		
Hepatitis/AIDS/HIV+		
Other illness not mentioned: _____		

<b>WOMEN ONLY</b>
Number of Pregnancies: _____
Date of Last Mammogram _____

<b>FAMILY HISTORY</b> Has any blood relative had the following... (Check Box)	Yes	No
Cancer. If so, type? _____		
Heart Disease/Hypertension		
Diabetes		
Other _____		

<b>REVIEW OF SYMPTOMS</b> Do you have the following... (Check Box)	Yes	No
Excess Scarring/Keloids		
Dry Eyes		
Chronic Cough/		
Shortness of Breath		
Chest Pain		
Depression/Mental Disorder		
Hepatitis/AIDS/HIV+		
Rapid or Irregular Heartbeat		
Skin Rash		
Intestinal Problems		
Joint or Muscle Pain		
Swollen Lymph Nodes		
Easy Bleeding/Bruising/		
Blood Disorder		
Weight Change		

<b>SOCIAL HISTORY</b> Do you have a history of... (Check Box)	Yes	No
Smoking. If so, how much? _____		
Alcohol Use		
Illicit Drug Use		

**PHYSICIAN USE ONLY**

HEENT \_\_\_\_\_ WNL \_\_\_\_\_ ABDOMEN \_\_\_\_\_ WNL \_\_\_\_\_

LUNGS \_\_\_\_\_ WNL \_\_\_\_\_ TRUNK \_\_\_\_\_ WNL \_\_\_\_\_

HEART \_\_\_\_\_ WNL \_\_\_\_\_ EXTREMITIES \_\_\_\_\_ WNL \_\_\_\_\_

OTHER \_\_\_\_\_ WNL \_\_\_\_\_ BREAST \_\_\_\_\_ WNL \_\_\_\_\_

PROPOSED PROCEDURE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DIAGNOSIS \_\_\_\_\_

CSC PSC MM/MEM ATRIUM PKR ERL/EE

TIME \_\_\_\_\_ ANESTHESIA \_\_\_\_\_ IP DS OS

PREORDERS \_\_\_\_\_

SUPPLIES \_\_\_\_\_

PER \_\_\_\_\_ DATE \_\_\_\_\_ EFFT \_\_\_\_\_ % O/P \_\_\_\_\_

DED \_\_\_\_\_ MET \_\_\_\_\_ PRECERT \_\_\_\_\_ PER \_\_\_\_\_

DATE/TIME \_\_\_\_\_ SCHEDULED WITH \_\_\_\_\_ PREPAY \_\_\_\_\_

SURGEON'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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**PHOTOGRAPHIC AUTORIZATION AND RELEASE**

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I, \_\_\_\_\_, authorize Associates in Plastic and Reconstructive Surgery, PC and/or his representative(s), to take photographs.

In addition, I authorize the use of these images, without compensation to me, for the following specific purposes:

*(Please initial in the boxes marked Yes or No for each item)*

Yes	No	
		in the office photo album for prospective patients.
		in our website for prospective patients.
		in print advertisements.
		on television.

I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Associates in Plastic and Reconstructive Surgery, PC.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**PRIVACY POLICY**

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I understand I have a right to review Associates in Plastic and Reconstructive Surgery, PC's Notice of Privacy Practices prior to signing this document. The Associates in Plastic and Reconstructive Surgery, PC's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Associates in Plastic and Reconstructive Surgery, PC. This Notice of Privacy Practices also describes my rights and the Associates in Plastic and Reconstructive Surgery, PC's duties with respect to my protected health information.

Associates in Plastic and Reconstructive Surgery, PC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature \_\_\_\_\_ Date \_\_\_\_\_