NORTHSHORE
PLASTIC SURGERY

Benjamin J. Boudreaux, MD
Jeffrey R. Claiborne, MD

Name: _____ Date: _____

Phone Number: _____ Referral Source: _____

Reason For Today's Visit: _____

Are You Currently Experiencing Any Of These Symptoms?

Severe Headaches	Y	N	Chronic Cough	Y	N
Dizziness	Y	N	Fever	Y	N
Chest Pain	Y	N	Diarrhea	Y	N
Shortness of Breath	Y	N	Unexplained Weight Loss	Y	N

Current or Previous Medical Problems: _____
_____

Prior Surgeries: __
_____

Age: _____ **Sex**: _____ **Height**: _____ **Weight**: _____

Medications (all prescribed and over-the-counter)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies: _____

Personal/Family History of Anesthesia Complications: _____
Personal/Family History of Bleeding/Clotting Complications: _____
Pacemaker or Defibrillator Device:_____

Social History
Occupation: _____
Smoking, Tobacco, Vaping or Nicotine Use and Amount: _____
Drug Use: _____

Female Patients – Pregnancy History
Number of Pregnancies _____ Number of Children _____

Pharmacy:_____ Phone:_____Address_____

Patient Signature: _____ Date: _____