Capital Cosmetic Surgery

Date:

NAME: (Last, First, Middle) ____________________

STREET ADDRESS: ____________________

CITY: __________ *STATE:* __________ *ZIP:* __________ *EMAIL ADDRESS:* __________

PHONE: (H): __________ (W): __________ (C): __________

DATE OF BIRTH: __________ SSN: __________ MARITAL STATUS: __________

EMPLOYER: __________ OCCUPATION: __________

INSURANCE CARRIER: __________ ID #: __________

GROUP #: __________

EMERGENCY CONTACT PERSON: __________ PHONE: __________

REASON FOR YOUR CONSULTATION/PROCEDURE OF INTEREST:

____

REFERRED BY/HOW DID YOU HEAR ABOUT US: __________

HEIGHT: __________ WEIGHT: __________

CURRENT MEDICATIONS: __________

____

ALLERGIES to medications or substances & the ensuing reaction: __________

____

SURGERY/HOSPITALIZATIONS

YEAR	HOSPITAL	REASON FOR HOSPITLIZATON

SOCIAL /HEALTH HABITS

Caffeine: __________
# of cups per day

Tobacco use (all forms): □ Never (no tobacco)
□ Former smoker (quite tobacco)
□ Occassional smoker
□ Current smoker (every day)

__________ # of years you have used tobacco

What types of tobacco: □ Cigarettes □ Pipe □ Chew/Snuff

Alcohol: □ Never □ Social Drinker (occassionally) □ Moderate (1-2 drinks/day)
□ Modest (3-4 drinks/week) □ Heavy (more than 2 drinks/day)