Patient's Name: _____

Nickname: _____

Address: _____

Street/Apt City State Zip

Home Ph: _____ Cell: _____ Fax: _____

Email: _____

Pharmacy: _____

Age: _____ DOB: _____SSN: _____Gender: [ ] Female [ ] Male

Marital Status: [ ] Single [ ] Married to: _____ Cell: _____

Other [ ] _____

Patient's Employer:_____

Occupation:_____

Work: _____ Ext: _____ Is it ok to call at work? [ ] Yes [ ] No

Employer's Address:_____

Referred by:_____

Phone: _____

Emergency Contact:_____Relationship:_____

Home Phone: _____ Work: _____

Other:_____

Primary Health Insurance:_____

Policy: _____Group: _____ Phone: _____

Insured Name:_____ DOB:_____ SSN: _____

Employer:_____ Relationship to Patient:_____

Secondary Health Insurance:_____

Policy: _____Group: _____ Phone: _____

Insured Name: _____DOB:_____ Employer:_____

I understand that office visit charges are payable on the day service is rendered. I authorize Georgios Ziakas, MD to bill my insurance company for medically necessary services. I hereby authorize the doctor to release all information necessary to secure the payment of benefits either by my insurance or financial institution (e.g. credit card company or issuing bank). Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between New Body Plastic Surgery and myself.

Signature: _____ Date: _____

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Patient Name: _____ **DOB:** _____

Confidential Record: Information contained herein will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

CHIEF COMPLAINT/ REASON FOR VISIT:_____

_____

_____

Please circle additional areas of concern that you would like to discuss with your doctor:

Face/ Forehead	Lips	Breasts	Brown spots/ freckles
Eyebrows	Chin	Arms	Moles
Eyelids	Cheek	Thighs	Scars
Eyelashes	Earlobes	Buttocks	Skin care products
Neck	Abdomen	Back	

Age: _____ Height: _____ Weight: _____

Current Physician: _____

Current Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Fax: _____

Do you currently take or have you taken Isotetrinoin (Absorica, Accutane, Amnesteem, Claravis, Sotret) in the past 12 months: [ ] Yes [ ] No

IF YOU ARE TAKING OR HAVE TAKEN THIS MEDICINE IN THE PAST 12 MONTHS

YOU SHOULD NOT

HAVE ANY ELECTIVE SURGICAL PROCEDURE INCLUDING SKIN LASERS OR DERMABRASION

ALLERGIES: Please list any medications, foods or materials such as latex that you are allergic to:_____

_____

_____

Please circle type of allergy:

Flushing Dizziness Hives Swelling Rash Anaphylaxis Other:_____

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Do you have any adverse reaction to any medication (please list):_____

Are you allergic to adhesive tape: (circle) Yes No

Are you allergic to iodine: (circle) Yes No

MEDICATIONS:

Please list all medications that you are currently taking or have taken within the last month. (Including over the counter, herbal medications, diet, or vitamin supplements). **Do you take contraceptives** (by mouth, vaginally or injection): Yes No

Name and strength	**Dose**	**Frequency (how often)**	**Date last taken**
1.			
2.			
3.			
4.			
5.			
6.			
7.			

SOCIAL HISTORY: (circle)

Do you smoke? Yes No If yes how many packs per day: _____ How long? _____years

Do you use recreational drugs? Yes No If yes list _____

Alcoholic beverages? Never Rarely Moderately Daily Type: _____

FAMILY HISTORY:

Family member	**Age (if alive)**	**Age (if deceased)**	**Cause of death**	**Serious illness (heart, diabetes, cancer)**
Father				
Mother				
Brother- Sister				
Brother- Sister				
Son- Daughter				
Son- Daughter				

REVIEW OF SYSTEMS: (circle)

Constitutional:	Fatigue	Fevers	**Eyes:**
Weight gain	Malaise	Itching	Changes in vision
Weight loss without trying to	Lethragy	Rashes	Frequent headaches
lose weight	Abnormal sleep	Lumps/ Masses	Eye pain
Night sweats	Loss of appetite	Falls	Dry eyes

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Double vision
Blind spots (scotomas)
Floaters
Retinal bleeding

ENT:
Runny nose
Nose bleeds
Sinus pain
Stuffy ears or nose
Ear pain
Ear ringing (tinnitus)
Gum bleeding
Toot aches
Sore throat
Trouble swallowing
Trouble hearing
Vertigo

CV:
Chest pain
Shortness of breath
Exercise intolerance
Waking up at night with trouble breathing
Swelling in legs or abdomen
Palpitations
Fainting
Passing out (loss of consciousness)
Pain in arms or legs while exercising or walking (claudication)
Heart attack
Stroke
Hypertension
Phlebitis
Varicosities

RS:
Cough (dry/ productive)
Sputum
Wheezing
Spitting blood (hemoptysis)
Shortness of breath
Exercise intolerance
COPD
Emphysema
Asthma
Tuberculosis
Sleep apnea

GI:
Abdominal pain
Weight loss (unintetional)
Trouble swallowing (solids, liquids, both)
Indigestion
Bloating
Anorexia
Cramping
Irritable Bowel
Food avoidance
Nausea
Vomiting (bloody, coffee grounds, bilious, undigested food)
Diarrhea (mucous, bloody, watery, undigested food)
Inability to pass gas
Constipation (acute or chronic)
Throwing up blood (hematemesis)
Rectal bleeding (hematochezia)
Tarry stools (melena)
Feeling that you have to go all the time (tenesmus)
Ulcerative colitis
Chron's disease
Colon cancer
Liver problems
Peptic ulcer disease
Reflux (GERD)
Esophageal varices

GU:
Urinary frequency (polyuria)
Urinary retention
Urinary incontinence
Pain with urination
Blood with urine (hematuria)
Waking up to urinate (nocturia)
Dribbling after urination
Trouble to start the stream of urination
Discharge from genitals or vagina
Painful periods
Irregular periods
Heavy periods
Longer periods
Genital hepres

MS:
Pain
Stiffness in joints or muscles
Joint swelling
Decreased range of motion
Decreased strength (weakness)
Arthritis
Crepitus in joints (cracking noise with pain)
Fractures
Neck pain
Back pain

Skin/ Breast:
Itching (pruritus)
Rashes
Striae
Skin lesions
Wounds
Scars
Surgical wounds
Nodules
Tumors
Eczema
Dryness
Discoloration
Breast pain
Breast masses
Nipple discharge
Breast cancer (including family history)

NS:
Changes in sight, smell, hearing, taste
Seizures
Fainting

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Migraines/ headaches
Weakness
Pins and needle sensation (paresthesias)
Arm weakness or numbness
Rt Lt
Leg weakness or numbness
Rt Lt
Poor balance
Speech problems
Losing urine or stool
Forgetfulness
Psychiatric problems

Psychiatric:
Depression
Sleep trouble
Anxiety
Bipolar
Schizophrenia (including family history)
Trouble concentrating
Unhappy with body image
Poor performance at work, school or home
Lack of energy
Paranoia

Eating disorders (bulimia, anorexia)
Frequent shopping sprees
Having impulses you cannot control
Blaming someone else for everything that is wrong in your life
Mood swings
Suicidal tendencies

Endocrine:
Thyroid problems (hyper or hypo)
Parathyroid problems (hyper or hypo)
Mood swings, depression
Frequent sweats
Diarrhea
Weight loss
Palpitations
Visual changes
Tremors
Menstrual changes (decreased or increased and heavy)
Voice changes

Hair loss or gain
Tremors
Dry skin
Cold intolerance
Hot intolerance
Constipation
Diabetes
Polyuria (urinating a lot)
Polydipsia (feeling thirsty all the time)
Polyphagia (hungry all the time)
Obesity
Hypertension that cannot be controlled
Episodic hypertension with hot flashes
Hypotension
Skin darkening on areas not exposed to sun (armpits)
Decreased libido
Erectile dysfunction

Hematologic/ lymphatic:
Anemia
Purpura
Petechias

Nose bleeds
Prolonged or excessive bleeding after tooth removal
Frequent miscarriages
Blood clots
Easy bruising
Easy bleeding
Using blood thinners (ASA, Plavix)
History of blood transfusion
Inability to donate blood
Hemophilia
HIV
Lymphoma
Leukemia
Hepatitis

Allergic/ Immunologic:
Anaphylaxis (trouble breathing)
Swelling of tongue, lips
Swelling in groins, armpits
Runny nose
Itching or teary eyes
Reaction to foods, animals, stings, medications

MEDICAL/ SURGICAL HISTORY:

Last physical exam date: _____ Chest X-Ray: _____EKG: _____

Mammogram: _____ Where/When: _____ Results: _____

Number of previous pregnancies: _____ Number of children: _____

Date of last menstrual period: _____Could you be pregnant? _____

Pap smear:_____ Where/ When: _____Results:_____

EGD/ Colonoscopy: _____Where/ When: _____ Results:_____

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Please list any Surgeries/ Illnesses/ Accidents and dates:_____

_____

_____

_____

_____

_____

_____

Have you previously had or been treated for any of the following? (circle)

Arthritis	Heart attack	Sleep apnea	Cancer (any type)
Fractures	Stroke	Emphysema	Leukemia
Anemia	Rheumatic fever	Peptic ulcer	Fever
AIDS/ HIV	Mitral valve prolapse	GERD	Blisters
Hepatitis	Chest pain (angina)	GI cancer (esophagus,	Poor Scarring
Glaucoma	Hypertension (high blood	stomach, bowels)	Bruising Problems
Cataracts	pressure)	Esophageal varices	Skin Disease
Eye Injury	Vascular Disease	Liver Disease	Bleeding Tendencies or
Impaired Sight	Diabetes	Gallbladder Disease	Blood Disorders
Heart disease	Asthma	Kidney Disease	Autoimmune Disease
Heart failure	COPD	Bladder Disease	
Problems with Anesthesia	Anxiety	Frequent or Severe	
Depression	Drug addiction	Headaches	

I verify that the above information is true and accurate to the best of my knowledge and I have not withheld any information from my doctor.

I understand that recommendations for treatment, including medications are made on the basis of the information I have provided.

Patient name:_____

Patient signature(or legal guardian if a minor):_____

Date:_____

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