

Upstate Plastic Surgery

301 The Parkway, Greer, SC 29650

Phone: (864) 968-0168

Fax: (864) 968-9248

Health Insurance Information: Please have your insurance card available for us to photocopy upon arrival to our office if you expect insurance to cover a non-cosmetic surgery.

Date _____ Patients Name _____ SS# _____

Mailing Address _____ Email _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Age _____ Date of Birth ____/____/____ Marital Status **M S D W** Sex **M F**

Reason for seeing Doctors Keller, Lovett or Blakemore _____

Occupation & Employer _____ Business Phone _____

Referred by: (please be specific)

Doctor _____ Upstate Skin Care & Spa _____ Yellow Pages _____

Friend _____ upstateplasticsurgery.com _____ Other Website _____

Relative _____ Seminar _____ Newspaper _____

Patient _____ Nurse _____ Other _____

Would you like to join our email list? YES NO

GENERAL MEDICAL INFORMATION

Who is your family or general medical doctor? _____

How is your general health? _____

Height _____ Weight _____

FEMALES

Last menstrual period _____

Are you pregnant? YES NO

Have you had a mammogram? YES NO

If yes, when and where was your last mammogram?

Have you had children? YES NO

If so, what are their ages? _____

MEDICATIONS

Are you taking aspirin, ibuprofen or any medication containing aspirin? YES NO

Are you taking blood thinners? YES NO

Have you taken any steroid cortisone preparations in the last year? YES NO

Are you taking Vitamin E? YES NO

Are you taking any herbal, fat burners or food supplements? YES NO

Have you ever used Acutane? YES NO

List any medications you are taking or have taken within the last month and the dosage: _____

ALLERGIES

Any drug allergies (including local anesthetics, antibiotics and/or codeine)? YES NO

Aspirin or ibuprofen allergy? YES NO

Tape allergy? YES NO

Allergy to Latex? YES NO

List any other allergies: _____

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PAST MEDICAL HISTORY/ REVIEW OF SYSTEMS

Chest

- Coronary occlusion YES NO
- Heart attack YES NO
- Angina or chest pain YES NO
- Congenital heart disease YES NO
- Heart murmur YES NO
- Rheumatic fever YES NO
- Palpitations/ irregular heartbeat YES NO
- High blood pressure YES NO
- Stroke YES NO
- Shortness of breath YES NO
- Chronic lung diseases YES NO

General

- Seizures or epilepsy YES NO
- Addison’s or adrenal disorder YES NO
- Thyroid disorder YES NO
- Skin problems (psoriasis, etc.) YES NO
- Liver disorder (including Hepatitis or Cirrhosis) YES No
- Gastrointestinal/digestive disorder YES NO
- Kidney, bladder disorders or chronic infection YES NO
- Spinal or back disorders YES NO
- HIV positive YES NO
- Vision problems YES NO
- Glaucoma YES NO
- Dry eyes requiring drops YES NO
- Asthma YES NO
- Hearing problems YES NO
- Sinus problems YES NO
- Frequent infections YES NO
- Previous blood clots or thrombophlebitis YES NO
- Any bleeding disorders in self or in family YES NO

- Blood transfusion YES NO
- Diabetes YES NO
- Autoimmune diseases YES NO
- Lupus or rheumatoid arthritis YES NO
- Any unusual healing problems YES NO
- Do you form keloids/thick scars? YES NO
- Do you get cold sores? YES NO

If you answered yes to any of the above, please explain:

PAST MEDICAL HISTORY

PAST SURGICAL HISTORY

SOCIAL HISTORY

- Do you smoke? YES NO
- Do you use other tobacco products? YES NO
- Do you consume alcoholic beverages? YES NO

FAMILY HISTORY

Any medical problems or illnesses in your family? YES NO

If yes, please explain: _____

Do you have or does anyone in your family have:

- Breast Cancer YES NO
- Skin Cancer YES NO

If yes, please explain: _____

Does anyone in your family have problems with anesthesia? YES NO

PSYCHIATRIC HISTORY

- Psychiatric treatment? YES NO
- If yes, were you hospitalized? YES NO
- Any recent crisis in your life? YES NO