ALAN BIENSTOCK, MD

Plastic & Reconstructive Surgery

REGISTRATION FORM

Name: ____________________ DOB:__________________ Age: _____ Date: ________

Address: _____________________ City: ___________ State: ______ Zip:___________

Home Tel: _____________________ Work Phone: _____________ Cell: _______________

Email: ____________________ SS#: _____________ Driver's Lic#: _________________

Marital Status: _____________ Employment Status (Full Time, Part Time): ____________

Employer Name: ____________________ Telephone #: ____________________________

If under 18: Guardian/Parent's Name _______________ Telephone #: ________________

Address of Parent/Guardian: ____

Spouse's Name: __________________________ Telephone #: ______________________

Spouse's Address (if different): ____

Emergency Contact: ____________________________ Telephone #: __________________

Pharmacy Name: __________________________ Telephone #: _______________________

Primary Physician: ___________________ Tel #: _______________ Fax #: ____________

Primary Insurance and Policy Holder

Name of Insurance: __________________________ Tel #: ___________________________

Billing Address: ____

Policy/ID #: _____________________________ Group #: ____________________________

Effective Date: ____________ Enrollment Date: ____________ Renewal Code: __________

Benefit Code: _____________________

Subscriber's Name: ___________________ DOB: ______________ SS#: _______________

Relationship to Patient: Self/Spouse/Child or Other: ___________________________________

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Medical History Questionnaire

Name: ____________________ **DOB:** __________________ **Date:** ________

Reason for visit: ____

____

Primary Doctor: ____

Past Medical History: ____

____

Do you have any of the following (Please Circle):

Diabetes	Hypertension	Prostate Problems
Asthma	Heart Disease	Mitral Valve Prolapse
Hepatitis	High Cholesterol	Pulmonary Disease
Reflux	Gastrointestinal Disease	Stroke
Ulcers	Heart Attack	Thyroid problems
Glaucoma	Kidney Disease	Autoimmune Diseases
Cancer	Heart Arrhythmia	

Past Surgical History (Type/Year): ________________________________

____

Have you had any of the following surgeries? (Please Circle):

Gallbladder removal	appendix removal	breast surgery
C-section	hernia repair	hemorrhoids surgery
Vascular surgery	tonsil surgery	pacemaker placement
Cancer surgery	heart surgery	Defibrillator placement
Colon surgery	skin excisions	Skin cancer removal

Gynecologic Surgery (Ovaries, Uterus)

Medications (Type/Dosage): ____________________________________

____

Are you taking any of the following (Please circle):

Aspirin	Motrin	Coumadin	Herbal Supplements
Ticlid	Plavix	Celebrex	

Allergies to Medicines (Describe the Reaction): ______________________________

____

Latex allergy? ____________________________________

OB/Gyn History

Pregnancies: ______________________________

Children: ______________________________

Last Menstrual Period: ______________________________

Last Mammogram: ______________________________

Family History: ____

____

Has any family member had the following(Circle and indicate Relationship):

Breast Cancer
Ovarian Cancer
Other types of Cancer
Diabetes
Arthritis
High Blood Pressure
Stroke
Heart Disease
Lung Disease
Kidney Disease
Psychiatric Illness (Depression, Manic Depression)

Social History

Employment: ____

Marriage Status: ____

Smoking History (Packs/Day & Years) ______________________________________

Alcohol Consumption (Amount/Day) ______________________________________

Children (number and age) ____

REVIEW OF SYSTEMS

CONSTITUTIONAL SYMPTOMS
Good general health lately .... No Yes
Recent weight change .... No Yes
Fever .... No Yes
Fatigue .... No Yes
Headaches .... No Yes

EYES
Eye disease or injury .... No Yes
Wear glasses/contact lenses .... No Yes
Blurred or double vision .... No Yes
Glaucoma .... No Yes

EARS/NOSE/MOUTH/THROAT
Hearing loss or ringing .... No Yes
Earaches or drainage .... No Yes
Chronic sinus problem or rhinitis .... No Yes
Nose bleeds... No Yes
Mouth sores .... No Yes
Bleeding gums .... No Yes
Bad breath or bad taste .... No Yes
Sore throat or voice change .... No Yes
Swollen glands in neck .... No Yes

CARDIOVASCULAR
Heart trouble .... No Yes
Chest pain or angina pectoris .... No Yes
Palpitation .... No Yes
Shortness of breath with walking/lying flat .. No Yes
Swelling of feet, ankles, or hands .... No Yes

RESPIRATORY
Chronic or frequent coughs .... No Yes
Spitting up blood .... No Yes
Shortness of breath.................................. No Yes
Asthma or wheezing .... No Yes

GASTROINTESTINAL
Loss of appetite .... No Yes
Change in bowel movements .... No Yes
Nausea or vomiting .... No Yes
Frequent diarrhea .... No Yes
Painful bowel movements or constipation . No Yes
Rectal bleeding or blood in stool .... No Yes
Abdominal pain .... No Yes

GENITOURINARY
Frequent urination .... No Yes
Burning or painful urination .... No Yes
Blood in urine .... No Yes
Change in force of stream when urinating .. No Yes
Incontinence or dribbling .... No Yes
Kidney stones .... No Yes
Sexual difficulty .... No Yes
Male — testicle pain................................. No Yes
Female — periods: pain/irregular (circle) .. No Yes
Female — vaginal discharge .... No Yes

MUSCULOSKELETAL
Joint pain .... No Yes
Joint stiffness or swelling .... No Yes
Weakness of muscles or joints .... No Yes
Muscle pain or cramps.............................. No Yes
Back pain... No Yes
Cold extremities .... No Yes
Difficulty in walking .... No Yes

INTEGUMENTARY (skin, breast)
Rash or itching .... No Yes
Change in skin color .... No Yes
Change in hair or nails.............................. No Yes
Varicose veins .... No Yes
Breast pain .... No Yes
Breast lump .... No Yes
Breast discharge .... No Yes

NEUROLOGICAL
Frequent or recurring headaches.............. No Yes
Light headed or dizzy .... No Yes
Convulsions or seizures .... No Yes
Numbness or tingling sensations .... No Yes
Tremors... No Yes
Paralysis .... No Yes
Stroke .... No Yes
Head Injury .... No Yes

PSYCHIATRIC
Memory loss or confusion .... No Yes
Nervousness .... No Yes
Depression.. No Yes
Insomnia .... No Yes

ENDOCRINE
Glandular or hormone problem .... No Yes
Thyroid disease .... No Yes
Diabetes(insulin or non insulin - circle one) No Yes
Excessive thirst or urination....................... No Yes
Heat or cold intolerance .... No Yes
Skin becoming dryer .... No Yes

HEMATOLOGIC/LYMPHATIC
Slow to heal cuts; bruising .... No Yes
Anemia .... No Yes
Phlebitis .... No Yes
Past transfusion... No Yes
Enlarged glands .... No Yes

ALLERGIC/IMMUNOLOGIC
History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics .... No Yes
- Morphine, Demerol, or other narcotics ... No Yes
- Novocaine, Lidocaine or other anesthetics No Yes
- Aspirin or other pain remedies .... No Yes
- Iodine, methiolate or other antiseptic . No Yes

Food or Drug allergies ....