New Patient History Form

Irvine Plastic Surgery Center
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NAME: _____ DATE: _____

REASON FOR TODAY'S VISIT: _____

_____

HAVE YOU BEEN SEEN IN THIS OFFICE BEFORE: ☐ YES ☐ NO

HAVE YOU SEEN ANY OTHER PHYSICIAN FOR THIS CONCERN? ☐ YES ☐ NO

DURATION OF THIS CONCERN? _____

PAST SURGERIES: _____

TO ASSIST US IN PROVIDING BETTER TREATMENT, HAVE YOU OR ARE YOU CURRENTLY SEEING A PSYCHOLOGIST, PSYCHIATRIST, OR COUNSELOR, OR HAS PSYCOLOGICAL TREATMENT BEEN RECOMMENDED IN THE PAST: _____

_____

ILLNESSES (SERIOUS): _____

LIST OF MEDICATIONS YOU ARE PRESENTLY TAKING: _____

_____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? ☐ YES ☐ NO

IF YES, PLEASE LIST: _____

DO YOU SMOKE? ☐ YES ☐ NO IF YES, HOW MANY PACKS A DAY: _____

DO YOU DRINK? ☐ NEVER ☐ OCCASIONALLY ☐ DAILY

OTHER FAMILY MEMBERS WHO ARE PATIENTS HERE: _____

_____

FOR WOMEN OF CHILD BEARING AGE, COULD YOU BE PREGNANT? ☐ YES ☐ NO

WHEN ARE YOU CONSIDERING HAVING THIS PROCEDURE(S)? _____