OLIVER P. SIMMONS, MD

PLASTIC SURGERY

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PATIENT INTAKE FORM

Date: _____ Reason for Your Visit:_____

Name: _____SSN: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (day): _____ Phone Number (evening): _____

Email Address: _____

Emergency Contact: _____

Preferred Language: _____ Race: _____ Ethnic Group:_____

Patient Insurance Information

Primary Insurance Company: _____

Claims Address:_____

Telephone:_____ Relationship to the Subscriber:_____

ID#_____ Group Name/#_____:_____

Subscriber SSN:_____ Subscriber Employer:_____

Subscriber Date of Birth:_____ Miscellaneous:_____

Secondary Insurance Company: _____

Claims Address:_____

Telephone:_____ Relationship to the Subscriber:_____

ID#_____ Group Name/#_____:_____

Subscriber SSN:_____ Subscriber Employer:_____

Subscriber Date of Birth:_____ Miscellaneous:_____

Preferred Pharmacy

Name: _____

Phone Number: _____

City or Zip Code: _____

Diplomat of the American Board of Plastic Surgery
Diplomat of the American Board of Facial Plastic Surgery
Diplomat of the American Board of Otolaryngology-Head and Neck Surgery

Past Medical History

Select any of the following medical conditions you currently have:

- [ ] Adrenal Insufficiency
- [ ] Anemia/Thalassemia
- [ ] Anxiety
- [ ] Arthritis
- [ ] Asthma
- [ ] Atrial Fibrillation (Irregular Heartbeat)
- [ ] Auto-Immune Disease
- [ ] Bipolar Disorder
- [ ] Blood Clotting Disorder
- [ ] BPH
- [ ] Breast Cancer
- [ ] Colon Cancer
- [ ] COPD
- [ ] Coronary Artery Disease
- [ ] Deep Venous Thrombosis
- [ ] Depression
- [ ] Diabetes
- [ ] Easy Bruising
- [ ] End Stage Renal Disease
- [ ] GERD
- [ ] Head Trauma
- [ ] Hearing Loss
- [ ] Hepatitis
- [ ] Hypertension
- [ ] Other _____
- [ ] HIV / AIDS
- [ ] Hypercholesterolemia
- [ ] Hyperthyroidism
- [ ] Hypothyroidism
- [ ] Lung Cancer
- [ ] Lupus
- [ ] Lymphoma
- [ ] Malignant Hypertension
- [ ] Mental Health Hospitalization
- [ ] Neuromuscular Disorder
- [ ] Paralysis
- [ ] Pneumothorax
- [ ] Prostate Cancer
- [ ] Pulmonary Embolism
- [ ] Radiation Treatment
- [ ] Renal Disorder
- [ ] Rheumatoid Arthritis
- [ ] Seizures
- [ ] Severe Reaction to Anesthesia
- [ ] Stroke
- [ ] Trauma
- [ ] Valvular Heart Disease
- [ ] Vision Loss
- [ ] None

Past Surgeries

Have you had any surgeries on the following organs?

- ☐ Abdominal Wall: Hernia Repair, Left Femoral
- ☐ Abdominal Wall: Hernia Repair, Right Femoral
- ☐ Abdominal Wall: Hernia Repair, Left Inguinal
- ☐ Abdominal Wall: Hernia Repair, Right Inguinal
- ☐ Abdominal Wall: Hernia Repair, Umbilical
- ☐ Abdominal Wall: Hernia Repair, Ventral
- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Brain: Brain Surgery for Cancer
- ☐ Brain: Brain Surgery for Trauma
- ☐ Breast: Mastectomy (Right Breast)
- ☐ Breast: Mastectomy (Left Breast)
- ☐ Breast: Mastectomy (Both Breasts)
- ☐ Breast: Lumpectomy (Right Breast)
- ☐ Breast: Lumpectomy (Left Breast)
- ☐ Breast: Lumpectomy (Both Breasts)
- ☐ Breast: Breast Biopsy
- ☐ Cesarean Section
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Esophagus: Esophagectomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: PTCA
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Heart Transplant
- ☐ Joint Replacement: Knee (Right)
- ☐ Joint Replacement: Hip (Right)
- ☐ Joint Replacement: Hip (Left)
- ☐ Joint Replacement: Hip (Both)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Nephrectomy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Lung: Left Lower Lobectomy
- ☐ Lung: Left Pneumonectomy
- ☐ Lung: Left Upper Lobectomy
- ☐ Lung: Right Lower Lobectomy
- ☐ Lung: Right Middle Lobectomy
- ☐ Lung: Right Pneumonectomy
- ☐ Lung: Right Upper Lobectomy
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries (Oophorectomy): Ovarian Cx
- ☐ Prostate (Prostatectomy: Prostate Cx
- ☐ Prostate (Prostatectomy): Prostate Bx
- ☐ Prostate (Prostatectomy): TURP
- ☐ Skin: Skin Biopsy
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Small Bowel Resection
- ☐ Spine Surgery
- ☐ Spleen (Splenectomy)
- ☐ Stomach: Gastrectomy
- ☐ Testicles (Orchiectomy)

- [ ] Joint Replacement: Knee (Left)
- [ ] Joint Replacement: Knee (Both)
- [ ] Other _____
- [ ] Uterus (Hysterectomy): Fibroids
- [ ] Uterus (Hysterectomy): Uterine Cancer
- [ ] None

Gynecologic History

LAST MENSTRUAL PERIOD

MM/DD/YYYY _____

LAST PELVIC EXAM

MM/DD/YYYY _____

LAST MAMMOGRAM

MM/DD/YYYY _____

LAST PAP SMEAR

MM/DD/YYYY _____

Obstetric History

GRAVIDA

PARA

TAB

SAB

Pediatric History

Gestational Age at Birth (in weeks)

☐ Weeks

Birth Weight ☐ lbs ☐ oz

Maternal illness during pregnancy _____

Forceps delivery ☐ Yes ☐ No

PATIENT INTAKE FORM

Skin Disease History

Have you had any of the following skin conditions?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Other _____
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous cell skin cancer
- ☐ None

Do you wear Sunscreen?

☐ Yes ☐ No

If yes, what SPF? _____

Do you tan in a tanning salon?

☐ Yes ☐ No

Family History

Do you have a family history of Melanoma?

☐ Yes ☐ No

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Other _____
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter

Plastic Surgery History

Abdomen: Abdominal Wall Reconstruction

- [ ] Abdomen: Abdominoplasty
- [ ] Body Contouring: Brachioplasty
- [ ] Body Contouring: Liposuction
- [ ] Body Contouring: Lower Body Lift
- [ ] Body Contouring: Thigh Lift
- [ ] Body Contouring: Upper Body Lift
- [ ] Breast: Breast Augmentation
- [ ] Breast: Breast Lift (Mastopexy)
- [ ] Breast: Breast Reconstruction
- [ ] Breast: Breast Reduction
- [ ] Breast: Correction of Nipple Inversion
- [ ] Breast: Implant Removal
- [ ] Breast: Nipple Reconstruction
- [ ] Burn Wound Reconstruction
- [ ] Carpal Tunnel Release
- [ ] Chemical Peel
- [ ] Cleft Lip Repair
- [ ] Cleft Palate Repair
- [ ] Cubital Tunnel Release
- [ ] Decubitus Ulcer Reconstruction
- [ ] Dermabrasion
- [ ] Ears: Ear Reconstruction
- [ ] Ears: Earlobe Repair
- [ ] Ears: Otoplasty
- [ ] Face: Blepharoplasty
- [ ] Face: Brow Lift
- [ ] Face: Cheek Augmentation
- [ ] Face: Chin Augmentation
- [ ] Face: Facelift

- [ ] Face: Facial Fracture Repair
- [ ] Face: Facial Reanimation
- [ ] Face: Frontal Sinus Fracture
- [ ] Face: Fronto orbital Advancement
- [ ] Face: Lefort Osteotomy
- [ ] Face: Lower Blepharoplasty
- [ ] Face: Mandible Fracture
- [ ] Face: Maxillary Fracture
- [ ] Face: Orbital Floor Fracture
- [ ] Face: Repair of Craniosynostosis
- [ ] Face: Upper Blepharoplasty
- [ ] Face: Zygoma Fracture
- [ ] Face: Flap Reconstruction
- [ ] Hair Restoration
- [ ] Hand: Extensor Tendon Repair(s), Left Upper Extremity
- [ ] Hand: Extensor Tendon Repair(s), Right Upper Extremity
- [ ] Hand: Flexor Tendon Repair(s), Left Upper Extremity
- [ ] Hand: Flexor Tendon Repair(s), Right Upper Extremity
- [ ] Hand: Ganglion Cyst Removal
- [ ] Hand Mallet Finger Repair, Left Upper Extremity
- [ ] Hand: Mallet Finger Repair, Right Upper Extremity
- [ ] Hand: Metacarpal Fracture Repair
- [ ] Hand: ORIF of Fracture, Left Upper Extremity
- [ ] Hand: ORIF of Fracture, Right Upper Extremity
- [ ] Hand: Phalangeal Fracture Repair
- [ ] Hand: Trigger Finger Release, Left Upper Extremity
- [ ] Hand: Trigger Finger Release, Right Upper Extremity
- [ ] Hand: Wrist Fracture Repair
- [ ] Laser Hair Removal
- [ ] Laser Resurfacing – CO2
- [ ] Laser Resurfacing – Erbium
- [ ] Nose: Rhinoplasty

- [ ] Nose: Septoplasty
- [ ] Orthopedic Hardware Coverage
- [ ] Scar Revision
- [ ] Skin Graft Reconstruction
- [ ] Sternal Wound Reconstruction
- [ ] Tendon Transfer
- [ ] Vascular Graft Coverage
- [ ] Wound Reconstruction

- [ ] Other

_____

Breast Cancer

Do you have a family history of breast cancer?

- [ ] Yes
- [ ] No

If so, which relative

- [ ] None
- [ ] Mother
- [ ] Father
- [ ] Sister
- [ ] Brother
- [ ] Daughter
- [ ] Son
- [ ] Uncle
- [ ] Other _____
- [ ] Aunt
- [ ] Nephew
- [ ] Niece
- [ ] Grandmother
- [ ] Grandfather
- [ ] Grandson
- [ ] Granddaughter

Malignant Hyperthermia and Anesthesia Sensitivity

Do you have a family history of malignant hyperthermia or severe reactions to anesthesia?

- [ ] Yes
- [ ] No

If so, which relative

- [ ] None
- [ ] Mother
- [ ] Father
- [ ] Aunt
- [ ] Nephew

- [ ] Sister
- [ ] Brother
- [ ] Daughter
- [ ] Son
- [ ] Uncle
- [ ] Other _____
- [ ] Niece
- [ ] Grandmother
- [ ] Grandfather
- [ ] Grandson
- [ ] Granddaughter

Herbal Medications and Supplements

Do you take any herbal medications or supplements?

- [ ] Yes
- [ ] No

Which herbal medications or supplements do you take?

- [ ] Anabolic Steroids
- [ ] Androstenedione
- [ ] Black Cohosh
- [ ] Cat's Claw
- [ ] Chondroitin
- [ ] Cranberry
- [ ] Echinacea
- [ ] Ephedra
- [ ] Evening Primrose
- [ ] Feverfew
- [ ] Fish Oil
- [ ] Flaxseed Oil
- [ ] Garlic
- [ ] Gingko Biloba
- [ ] Ginseng
- [ ] Glucosamine
- [ ] Goldenseal
- [ ] Green tea
- [ ] Hawthorn
- [ ] HCG
- [ ] Horse Chestnut
- [ ] Human growth hormone
- [ ] Kava
- [ ] Licorice Root
- [ ] Mistletoe
- [ ] Peppermint
- [ ] Phentermine
- [ ] Red Clover
- [ ] Saw Palmetto
- [ ] St. John's Wort
- [ ] Valerian
- [ ] Vitamin A
- [ ] Vitamin B
- [ ] Vitamin C
- [ ] Vitamin D
- [ ] Vitamin E

Other:_____

Medications

List all current medications:

_____

_____

_____

Allergies

List all allergies and reactions if known:

_____

_____

_____

LATEX Allergy: ☐ Yes ☐ No Contact/Blood Precautions?_____

Social History

Smoking Status (please choose one)

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Smoker current status unknown
- ☐ Unknown if ever smoked

Start Smoking

MM/DD/YYYY _____

Quit Smoking

MM/DD/YYYY _____

Number of Packs Per Day: ☐

Total Years Smoking: ☐

Social History Details

Alcohol Intake: ☐ None

☐ 1 or less per day

☐ 1-2 per day

☐ 3 or more drinks per day

Driving Status

☐ Drives in the Daytime ☐ Drives at Night

How often do you exercise?

☐ Unspecified
☐ Several times a day
☐ Once a day
☐ A few times a week
☐ A few times a month
☐ Never
☐ Other _____

What is your caffeine use?

☐ Unspecified
☐ Several times a day
☐ Once a day
☐ A few times a week
☐ A few times a month
☐ Never
☐ Other _____

Occupation and Workplace_____

Place of Residence_____

Referred by:_____

How did you hear about us:_____