PATIENT INFORMATION

Date:_______________

Name:____ SS#:______________________

Address:____ Apt#:_____________

City:____ State:_____________ Zip Code:__________

Home #:_______________________________________ Cell #:____________________________

DOB:________________________ Sex:_________ Marital Status:_____________________

Race:________________________ Language:___________ Hispanic/Latino: ( ) NO ( ) YES

E-Mail Address:____

Emergency Contact:__________________________________ Relationship:___________________

Home #:__________________________________ Work#:______________________________

Referring MD:____________________________ Primary Care MD:______________________

How did you hear about us?____

Has there been any change in your insurance information?__________________________________

MEDICAL HISTORY UPDATE

Pharmacy Name:____________________________ Phone Number:________________________

Pharmacy Location:____

S. DARRELL LEE, M.D.
MEDICAL/SURGICAL HISTORY INFORMATION

Name: ______________________________ **Date:** ________________

Pharmacy Name: ______________________________ **Phone Number:** ________________

Pharmacy Location: ______________________________

List all previous surgeries and hospitalizations: ______________________________

____

____

Are you allergic to any medications? ( ) NO ( ) YES **If YES, list medications:**

____

____

List ALL medications you are taking including over the counter medications, herbs, vitamins, teas, diet pills and dietary supplements:

Medication(s)	Dosage	How often

Check any of the following diseases which you have or have had:

□ Emphysema	□ High/Low Blood Pressure	□ Tuberculosis
□ Rheumatic fever	□ Heart Murmur	□ Cancer
□ Glaucoma	□ Irregular/Fast Heartbeat	□ Ulcers
□ Pneumonia	□ Seizure Disorder/Epilepsy	□ Angina
□ Fainting Spells	□ Stomach Problems	□ Bronchitis
□ Excessive Bleeding	□ Blood Transfusion Reaction	□ Stroke
□ Psychiatric Care	□ Prostate Problems	□ Asthma
□ Thyroid Disorder	□ Gout/Arthritis	□ Diabetes
□ Circulatory Problems	□ Pancreas Disorder	□ Cataracts
□ Liver Disease/Hepatitis	□ Gall Bladder	□ Other:
□ Dry Eye Syndrome	□ Kidney or Bladder Infections	□

FAMILY HISTORY: list immediate family members either deceased (with cause of death and age) or living with serious illness: ____

____

____

SOCIAL HISTORY: Please check and answer all of the following questions:

Yes	No	
( )	( )	Do you have any skin problems? If yes, please describe: Rash__________ Bleeding__________ Bruising__________
( )	( )	Do you smoke? If yes, how much per day?__________
( )	( )	Are you a former smoker? If yes, when did you stop?__________
( )	( )	Do you drink alcoholic beverages? If yes, how much per day?__________
( )	( )	Do you have vision problems? If yes, please explain: __________
( )	( )	Do you wear eyeglasses?
( )	( )	Do you wear contact lenses?
( )	( )	Do you wear removable denture appliance/denture?
( )	( )	Do you now or have ever used "street drugs"?
( )	( )	Do you wear hearing aids?
( )	( )	Do you have breathing problems? If yes, please explain: __________
( )	( )	Do you have a cough? If yes, please describe: ( ) Moist ( ) Dry ( ) Hacking
( )	( )	Are you on a special diet? If yes, please explain: __________
( )	( )	Do you have any disease, condition or problem not listed that you think Dr. Lee should know about? If yes, please explain: __________
( )	( )	Do you have any reason to believe you are pregnant?

NOTICE OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES*

S. Darrell Lee, M.D.
Lee Plastic Surgery & Laser Center
525 NW Lake Whitney Place, Suite 206, Port Saint Lucie, FL 34986

I hereby acknowledge that I have received the Notice of Privacy Practices from your office, the practice of S. Darrell Lee, M.D..

Patient signature:

______________________________________ ______________
Date

Printed name of patient:

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