Dean E. Sorensen, MD, FACS

Name: Date:

Date of Birth: Age:

Address: City & State: Zip:

Home Phone: **Work Phone:** **Cell Phone:**

Have you been to our website **www.deansorensenmd.com** **YES** **NO**

How did you hear about our Office? Web Phonebook Doctor Friend Other

Email:

Your Employer: Occupation:

Primary Care Physician:

Marital Status: Single Married Divorced Widowed Spouse's Name:

Emergency Contact:____________________________________ Relationship:________________________
Emergency Phone Number:____

AREAS OF INTEREST: (Mark all the apply)

__Blepharoplasty (Eyelid)
__Botox
__Dermal Fillers (Lips, Cheeks, etc.)
__Earlobe Repair
__Rhytidoplasty (Face or Neck Lift)

__Otoplasty (Ear Pinning)
__Rhinoplasty (Nose Reshaping)
__Skin Resurfacing (Laser/Peel)
__Labiaplasty
__Liposuction (Thighs, Abdomen, Etc.)

__Breast Reduction
__Mastopexy (Breast Lift)
__Breast Reconstruction
__Abdominoplasty (Tummy-Tuck)
__Breast Augmentation

SURGICAL HISTORY (Including cosmetic history)

MEDICAL HISTORY

Do you have any health problems (arthritis, back problems, kidney stones, diabetes, seizure disorders, heart, etc.)?
YES NO

Do you have any problems with bruising, bleeding, blood clots etc.? YES NO

Do you get fever blisters or other cold sores on your lips? YES NO If yes, how often?

Have you ever been seriously injuried? Explain:

Are you Allergic to latex? YES NO

Are you allergic to any medications? YES NO If so please list drug allergies & reactions:

HABITS

Have you ever smoked or do you currently smoke? YES NO If yes, how much?

Please list **ALL medications** you have recently taken or are currently taking:
(including aspirin or ibuprofen products and vitamins/supplements)

MEDICATIONS:	*what its used for:*

GYNECOLOGICAL HISTORY (female patients)

Pregnancies: Normal Deliveries: Miscarriages/Abortions:

FAMILY HISTORY

Are your parents living? YES NO If not, please list age and cause of death:

List all diseases that run in your family:

REVIEW OF SYSTEMS

Have you ever had any serious problems with the following?

Eyes?	YES	NO	Heart?	YES	NO	Bowel Habits?	YES	NO
Ears?	YES	NO	Lungs?	YES	NO	Urinary?	YES	NO
Nose?	YES	NO	Breasts?	YES	NO	Neurological?	YES	NO
Throat?	YES	NO	Indigestion?	YES	NO	Psychiatric?	YES	NO

What is your current weight: Ideal weight? Height?

NOTICE OF PRIVACY PRACTICES

Your medical information is confidential

Our ethics and polices require that your person medical information be held in strict confidence.
We do not release pertinent medical information without our patients written consent.

We protect your information

We maintain protocols to ensure the security and confidentiality of your personal medical information. We have physical security in our building, passwords to protect data bases, compliance audits and virus intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their job.
The complete synopsis of our privacy practices is available to you- our patient- upon request.
Please contact our staff for a copy of this information for your records and/or review.

Dr. Dean E. Sorensen, MD, FACS

Patient Signature: **Date**