John Williams, MD
Plastic Surgery

Patient Information

Confidential Information: The information herein will not be released except when you have authorized us to do so. This information will be used by the doctors in their decisions regarding your care.

Name: ____ Date: ________________________

Parent or Guardian's Name (for minors): ____

Address: ____

City: ____________________________ State: ____________________ Zip: ___________________

Telephone Numbers: Home: _________________ Cell: __________________ Work: __________________

Occupation: __________________________________ Employer: __________________________________

E-mail Address: ____ Please check: □ Okay to use □ Do not use

Date of Birth: ________________ Age: ________ Height: ________ Weight: ________ □ Female □ Male

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Spouse's name: __________________________________ Number: _______________________________

Emergency Contact: Name: __________________________________ Number: _______________________

Date of last physical exam: ________________ Chest X-Ray: ________________ EKG: _________________

Primary care physician: __________________________________ Phone: ____________________________

How did you hear about us? ____

What can we help you with today or in the future? ____

Are you interested in Care Credit Financing? □ Yes □ No If yes, please fill out the following:

Social Security Number: _________________________ Driver's License Number: ______________________

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www.facebook.com/scottsdalesurgeon

Medical History

Your health is of extreme importance to us. The more we know about you, the better we can assist you. Please complete the following information as completely as possible.

Do you have or have you had any of the following? (Please check yes or no)

	YES	NO		YES	NO
AIDS or HIV positive	□	□	Hepatitis	□	□
Anemia	□	□	High blood pressure	□	□
Arthritis	□	□	Irregular heart beat	□	□
Asthma	□	□	Kidney problems	□	□
Back problems	□	□	Migraine headaches	□	□
Blood clots in legs	□	□	Nervous breakdown	□	□
Blood disorders	□	□	Nose/throat problems	□	□
Bleeding problems	□	□	Pneumonia	□	□
Breathing problems	□	□	Psychiatric condition	□	□
Cancer	□	□	Rheumatic Fever	□	□
Chest pains	□	□	Seizures	□	□
Colitis	□	□	Shortness of breath	□	□
Diabetes	□	□	Skin cancer	□	□
Ear/eye problems	□	□	Stomach problems	□	□
Epilepsy	□	□	Stroke	□	□
Heart problems	□	□	Thyroid problems	□	□
Heart murmur	□	□	Tuberculosis	□	□
Heart palpitations	□	□	Transfusion	□	□

Have you had any serious illnesses not listed? ____

List any illnesses that run in your family ____

Do you Smoke? □ Yes □ No If yes, how much and for how long? ____

Do you regularly drink alcohol? □ Yes □ No If yes, how much and how often? _______________________________

List ANY medications, vitamins or herbs taken in the last month ____

____

List any **allergies** to medications, tape, etc… ____

List all previous surgeries and dates (including cosmetic procedures) ____

____

Have you ever had any complications following anesthesia? □ Yes □ No

Do you have aspirin or blood thinners on a regular basis? □ Yes □ No

Do you bruise easily? □ Yes □ No

Do you bleed excessively following a tooth extraction? □ Yes □ No

Have you ever had a blood transfusion? □ Yes □ No

Women only: Is there a chance you might be pregnant? □ Yes □ No