Mark G. Albert, M.D.

PLASTIC AND RECONSTRUCTIVE SURGERY

Name: _____ Age: _____ Sex: M / F
Last First Middle

DOB:_____ SSN: _____

Mailing Address: _____
Street City State Zip

Mobile Phone: _____ Work Phone: _____ Home Phone: _____

Email Address: _____ Driver's license # _____

Preferred Method of Contact: _____

Do you have: 1) a medical power of attorney? ☐ Yes ☐ No 2) a living will? ☐ Yes ☐ No

How do you plan to pay for your medical care? ☐ Cash ☐ Credit card ☐ Financing ☐ Insurance

EMERGENCY CONTACT

Emergency Contact Person: _____ Relationship to You: _____

Phone: _____ Alternate Phone: _____

EMPLOYMENT INFO

Employment status (circle): Full-time Part-time Unemployed

Employer: _____

Department: _____ Position: _____

HEALTH INSURANCE INFO (Optional for cosmetic patients)

Primary Insurance Company & Plan:_____

Policy holder's Name: _____Relationship to You: _____

Policy holder's DOB: _____ Policy holder's SSN: _____

Insurance ID # _____ Group # _____

HOW DID YOU HEAR ABOUT DR. ALBERT?

☐Internet _____ ☐Doctor: _____ ☐Friend: _____

☐Advertisement: _____ ☐ER Visit?_____

MEDICAL INFORMATION

BRIEFLY, WHAT IS THE PURPOSE OF YOUR VISIT?

_____

PAST MEDICAL HISTORY

WHAT ONGOING MEDICAL PROBLEMS DO YOU HAVE?

_____

PLEASE LIST ANY SURGERIES/PROCEDURES THAT YOU HAVE HAD.

_____ _____
Type Type

_____ _____
Type Type _____

BESIDES THE SURGERIES, HAVE YOU BEEN IN A HOSPITAL OR HAD SERIOUS INJURIES?

_____

ADDITIONAL MEDICAL PROBLEMS

GENERAL
- Weight gain or loss Y / N
- Weakness/fatigue Y / N
- Fever, chills, night sweats Y / N

EYES
- Glasses or contacts Y / N
- Pain or redness Y / N
- Cataracts Y / N
- Blurred vision Y / N
- Double vision Y / N
- Dry eyes Y / N

EARS/NOSE/MOUTH/THROAT
- Hearing difficulty Y / N
- Ringing Y / N
- Earaches Y / N
- Allergies/sinus Y / N
- Frequent colds Y / N
- Nose bleeds Y / N

RESPIRATORY
- Cough Y / N
- Wheeze Y / N
- Shortness of breath Y / N
- Pneumonia Y / N

CARDIAC
- Chest discomfort Y / N
- Palpitations Y / N

GASTROINTESTINAL
- Swallowing Y / N
- Nausea and vomiting Y / N
- Blood in stool Y / N
- Abdominal pain Y / N

MUSCULOSKELETAL
- Leg cramps Y / N
- Other muscle cramps Y / N
- Back pain Y / N
- Joint pain/stiffness Y / N
- Weakness Y / N
- Tingling/numbness Y / N
- Leg cramps w/ walking Y / N
- Pain in feet Y / N

URINARY
- Increased frequency Y / N
- Burning Y / N
- Urinating at night Y / N
- Incontinence Y / N
- Blood in urine Y / N
- Decreased force Y / N

ENDOCRINE
- Thyroid trouble Y / N
- Diabetes Y / N
- Hormonal imbalances Y / N

NEUROLOGIC
- Fainting Y / N
- Seizures Y / N
- Shaking Y / N
- Loss of memory Y / N
- Headaches Y / N
- Head injury Y / N
- Hand or leg weakness Y / N
- Numbness Y / N
- Facial droop Y / N
- Slurred speech Y / N
- Unilateral eye blindness Y / N
- Stroke Y / N

SKIN
- Rashes Y / N
- Lumps Y / N

HEMATOLOGIC/LYMPHATIC
- Anemia Y / N
- Bleeding problems Y / N
- Transfusion reaction Y / N
- Blood clots Y / N

ALLERGIES, IMMUNE PROBLEMS
- Food allergies Y / N
- Recurrent infections Y / N
- Wound healing problems Y / N

PSYCHIATRIC
- Anxiety Y / N
- Depression Y / N
- Mood swings Y / N

BREAST
- Lumps Y / N
- Nipple discharge Y / N
- Pain Y / N
- Date of last mammogram _____

REPRODUCTIVE HISTORY
- Age at 1st menstruation: _____
- # Pregnancies: _____
- # Live births: _____
- Age at menopause: _____
- Last menstrual period: _____
- Last pap smear: _____
- Birth control pills? Y / N
- Hormone supplementation? Y / N

If you answered yes to any of the above, please explain:
_____
_____
_____
_____
_____

Have you ever had cancer? Y / N If yes, provide details:
_____
_____
_____

PLEASE INDICATE ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

HAVE YOU HAD AN ADVERSE REACTION OR ALLERGY TO ANY MEDICATION? Yes ☐ No ☐
(include herbal and OTC)

If yes, please explain:
_____

FAMILY HISTORY

	Living?	Anesthesia/Clotting/Bleeding Problems?
Father	Y / N	_____
Mother	Y / N	_____
Siblings	Y / N	_____
	Y / N	_____
Children	Y / N	_____

SOCIAL HISTORY

Marital Status: Single If single, do you live alone? Y / N

Married If married, for how long? _____
Spouse's name: _____

Do you have family members that live nearby? Y / N Where? _____

What is your occupation? _____ For how long? _____

Smoking status? Never/Active/Quit How much? _____ How many years? _____

Do you drink alcoholic beverages? Y / N How much and how often? _____

Do you use recreational drugs of any kind? Y / N Which drugs and how often? _____

Are you a student? Y / N
If so, where? _____

Major academic interest? _____

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VITAL SIGNS (to be completed by Staff only)

Height: _____ Weight: _____

Temp: _____ HR: _____ BP: _____

Date: _____Account # _____Reviewed by: _____