Today's Date: _____

AESTHETIC CENTER
FOR BREAST AND COSMETIC SURGERY, PA
Sutton L. Graham II, MD

Patient History

Name: _____ Date of Birth: _____
Age: _____ Height: _____ Weight: _____ Occupation: _____
Primary care physician: _____ Date of last physical: _____
Physician Address: _____ Phone number: _____

Do you smoke? _____ Packs per day: _____ #of years: _____ Ex-smoker? _____ How long? _____
Do you have a tendency towards motion sickness? _____
Have you experienced postoperative nausea and vomiting? _____

List drug allergies and sensitivities: _____
List all food allergies: _____
Have you ever experienced an unexplained allergic reaction during surgery or other medical or dental procedures?____ If yes, please explain: _____

Have you experienced itching, sneezing, wheezing, or hives when exposed to rubber or **latex**? _____
Is your skin sensitive to tape or Band-Aids? _____

Have you or a family member experienced unexpected problems following general anesthesia or exercise? _____ If yes, please explain: _____
Symptoms may include: high fever, dark or chocolate colored urine, muscle spasms or weakness, and/ or breathing problems or difficulty awakening after surgery.
Have you been diagnosed with a muscle or neuromuscular disorder? _____
Have you or a family member been diagnosed with malignant hyperthermia? _____

Do you have sleep apnea? _____Do you use a CPAP machine? _____
Have you been diagnosed with TMJ? _____ Do you snore? _____

Medications

Please list all medication which you are currently taking or have used in the past six months. Please include any herbal supplements you are currently taking.

Medication	Dose	Frequency

Medical History

Yes	No	
		Heart Disease (Please Circle): Heart Attack / Angina / High Blood Pressure / Failure / Irregular Rhythm / Rheumatic Fever / Mitral Valve Prolapse / Other:
		Have you ever seen a cardiologist? If yes, please give: Physician Name: Date of Last EKG:
		Lung Disease (Please Circle): Bronchitis/ Asthma / Wheezing / Emphysema/ TB Allergies / Shortness of breath / Difficulty breathing / Other:
		History of (Please Circle): Stroke / Epilepsy / Seizures / Syncope
		Gastrointestinal (Please Circle): Hiatal Hernia / Heartburn / Ulcers / Other:
		History of urinary problems (Please Circle): Retention / Incontinence / Frequent Bladder Infections / Other:
		Other Illness (Please Circle): HIV / Hepatitis / Jaundice / Anemia / Other:
		Bleeding Tendencies or Blood Clots
		History of Cancer (If yes, please indicate where)
		Endocrine: Diabetes / Thyroid
		Current Illnesses (Please Circle): Cold / Flu / Other:
		Implanted Devices (Please Circle): Hip / Knee / Lens / Other:
		Do you wear (Please Circle): Glasses / Contact Lenses
		Do you have (Please Circle): Dentures / Caps / Bridges / Veneers / Braces / Loose or Chipped Teeth / Other:
		Is there any possibility you may be pregnant? Last Menstrual Period:
		Do you drink caffeine? If yes, how much? Do you drink alcohol? If yes, how much?
		In the past six months have you used (Please Circle): LSD/ Speed/ Cocaine/ Marijuana/ Other

Surgical History

Please list all previous surgeries (include cosmetic or plastic surgery.)	Approximate Date

For office use only: Temp _____ BP: _____ SaO2: _____ Pulse: _____ Resp: _____

Airway:_____ Heart:_____ Lungs: _____

_____ None _____ CXR _____ EKG _____ BMP _____CBC _____ Other _____

Medical history reviewed: Date:
Anesthesia notes:

ASA Status: I II III IV

NEW PATIENT INFORMATION

AESTHETIC CENTER FOR BREAST AND COSMETIC SURGERY, P.A.
SUTTON L. GRAHAM II, M.D.

PERSONAL:

PATIENT'S NAME (PLEASE PRINT)		HOME PHONE #	MARITAL STATUS S M W D SEP	BIRTH DATE / /	AGE
STREET ADDRESS		BUS. PHONE #	FAMILY PHYSICIAN'S NAME		
CITY AND STATE	ZIP CODE	CELL PHONE #	REFERRED BY		
DRUG ALLERGIES		EMAIL ADDRESS			
REASON FOR SEEING THE DOCTOR			EMERGENCY CONTACT		

INSURANCE INFORMATION: Please bring your insurance card.

NAME OF INSURED, (i.e. SPOUSE, PARENT)	DATE OF BIRTH	INSURED'S EMPLOYER
INSURED ID #		EMPLOYER'S STREET ADDRESS
OCCUPATION		CITY AND STATE ZIP CODE

AUTHORIZATIONS & AGREEMENTS:

1. CONSENT TO TREAT: I request that the physicians and staff of this practice provide treatment to me (or my dependent).
2. RESOLUTION OF CONCERNS: I understand that I am entering into a contractual relationship with the physician and practice for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. I agree not to advance any false, meritless, and/or frivolous claim of medical malpractice. Furthermore, should a meritorious case be initiated or pursued, I (&/or my representative) agree to use only American Board of Plastic Surgery board-certified expert medical witness(es). Furthermore, I agree that these expert witnesses will be members of and adhere to the guidelines and / or code of conduct defined for expert witnesses by the American Society of Plastic Surgeons. In further consideration for this the physician agrees to the same stipulations.
3. INSURANCE: I authorize payment of medical & surgical benefits directly to Aesthetic Center for Breast & Cosmetic Surgery, PA. ("assignment of benefits"). I understand that I am responsible for any co-payment, deductible, and amounts determined to be noncovered.
4. PRIVACY: We have always carefully respected our patient's privacy, Regulations require that we request your signature to indicate that we offered you a copy of our Notice of Privacy Policies. It is available on our website or at the front desk.
5. RELEASE OF MEDICAL INFORMATION: I authorize release of medical information to the responsible insurance companies / health benefit plans. I also authorize release to physicians and hospitals involved in my past and future care.
6. MEDICAL PHOTOGRAPHY: I authorize photographs to be made as part of the medical record.

SIGNATURE (PATIENT AND/OR AUTHORIZED PERSON IF PATIENT IS UNDER 18 YEARS OF AGE) _____ DATE _____