GEOFFREY R. KEYES, M.D.

CASE HISTORY FILE

Date:___________________

Patient's Name _____________________________________ Age________ Date of Birth_______________________

Home Address____________________________________ City____________________ State______ Zip__________

Home Phone_______________________________ ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Cell Phone ________________________________ Patient's Employer: _____________________________________

Business Phone _____________________________ Patient's Occupation: ___________________________________

Email Address____________________________________ I respond best to : ☐ Email ☐ Telephone

Drivers License Number: ______________________________________

Name of Spouse____________________________________ Spouse's Contact Number: ________________________

Patient referred by: ☐ Internet (☐ nasalsurgery.org ☐ keycare.com ☐ Google ☐ asaps.com)

☐ Friend/relative: ________________________ ☐ M.D. Referral: ______________________

☐ Other: ________________________

Emergency Contact:______________________________ Relationship_____________________________

Phone: ____

(***not living at same address as patient***)

INSURANCE INFORMATION ☐ Copy of Card Given to Office

Insurance Company______________________________________ Policy No.________________________________

Social Security No. of Policy Holder: ______-________-________ Phone: ( ) ____________________________

PERSON FINANCIALLY RESPONSIBLE : ☐ Self ☐ Other

Name____ Relationship______________________________

Phone: ( ) _______________- __________________

PRESENT PROBLEM

Specific problem(s) for which you are seeking plastic surgery. _______________________________ Primary/Revision?

Have you consulted any other doctors, including plastic surgeons, about this? No_____ Yes______

If yes, please list their names____

 P.T. #: _______________

PAST MEDICAL HISTORY

General Health: Good __ Fair __ Poor__
If not "Good". Please explain: ____

Weight loss or gain in past year__________________ lbs. Loss______ Gain______

When was your most recent physical check-up? ____________________

Did It Include an EKG? No _____Yes____ Chest X-ray? No____ Yes____

Name and address of Doctor____
(Name) (Phone)

Serious Illnesses (Please List)	Previous Surgery (Please List)	Injuries (Please List)
☐ _______________________	☐ ______________________	☐ ____________________
☐ _______________________	☐ ______________________	☐ ____________________
☐ _______________________	☐ ______________________	☐ ____________________

Have you had significant complications or after effects from any of the above? No____ Yes____
If "Yes", please explain
____
____

Are you allergic or have any sensitivities to any medicines? Yes__________ No ___________

If yes, which one(s)? PENICILLIN SULFA OTHER: ____

Date of Last Normal Menstrual Cycle: _____/_____/_______ ☐ Not Applicable

Pregnancies_______ Miscarriages__________ Abortions______________

What is your approximate daily consumption of the following?
Caffeine __________ Alcohol___________ Tobacco ___________ Other mind altering drugs______________

Please list all medications you are now taking and their dosages including birth control pills, diet pills (prescription or over the counter) diuretics (water pills), blood thinners (aspirin, buffrin, etc.), blood pressure or heart medications, tranquilizers, hormones, etc.

☐ _______________________ ☐ ________________________ ☐ _____________________________

☐ _______________________ ☐ ________________________ ☐ _____________________________

 P.T. #: ____________

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In compliance with California OSHA Title 8, Section 5199, health care facilities must prescreen patients for aerosol transmissible diseases. Procedures are not performed on patients suspected or identified as having aerosol transmissible diseases.

PATIENT SCREENING FOR AEROSOL TRANSMISSIBLE DISEASES (ATD)

Do you have (circle): A history of Tuberculosis or symptoms of Tuberculosis? (Productive Cough (> 3 weeks), Blood Sputum, Fever, Night Sweats, Fatigue, Malaise, Unexplained Weight Loss)

No ____

If yes, please explain: ____

Do you have (circle): Flu & Other Aerosol transmissible diseases, including pertusis, measles, mumps, rubella, chicken pox, meningitis? (Body Aches, Runny Nose, Sore Throat, Headache, Nausea, Vomiting, Diarrhea, Fever and Respiratory Symptoms, Severe Coughing Spasms, Painful-Swollen Glands, Skin Rash-blisters, Stiff Neck, Mental Changes)

No ____

If yes, How long? ________ Please explain: ____

Chronic Respiratory Diseases (Not ATD's and not considered infectious) do not disqualify a patient from treatment under California OSHA Title 8, Section 5199:
Do you have (circle): Chronic upper airway cough syndrome "postnasal drip," Gastro esophageal reflux disease (GERD), Chronic obstructive pulmonary disease (COPD), Dry cough from ACE inhibitors, Bronchitis, Emphysema, Allergies, Asthma.

No ___

FAMILY HISTORY

HAS ANY RELATIVE EVER HAD:				AGE	STATE OF HEALTH
Tuberculosis	Y	N	Father	____	Good / Fair / Poor
Cancer	Y	N	Mother	____	Good / Fair / Poor
Epilepsy	Y	N	Brother(s)	____	Good / Fair / Poor
Heart Disease	Y	N		____	Good / Fair / Poor
Mental Disease	Y	N	Sister(s)	____	Good / Fair / Poor
Lung Disease	Y	N		____	Good / Fair / Poor
Kidney Disease	Y	N	Children	____	Good / Fair / Poor
Blood Disorders	Y	N		____	Good / Fair / Poor
High Blood Pressure	Y	N		____	Good / Fair / Poor
Asthma/Breathing	Y	N		____	Good / Fair / Poor

 P.T.#____________

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IMPORTANT PREOPERATIVE INFORMATION

Have you ever reacted badly to being put to sleep for surgery? **Yes No**

Has any member of your family ever reacted badly to being put to sleep for surgery? **Yes No**

Is there a family or personal history of Malignant Hyperthermia and/or any known atypical response to anesthesia? **Yes No**

Is there a family or personal history if a muscle or neuromuscular disorder (e.g. muscle weakness, serious muscle cramps, etc.)? **Yes No**

Have there been unexpected deaths or complications arising from anesthesia (including within dental office) with any family members or blood relatives? **Yes No**

Is there a personal history of dark or cola-colored urine immediately following anesthesia or serious exercise? **Yes No**

Is there a personal history of unexplained and unanticipated high fever either during or within the first several hours following surgery? **Yes No**

Is there a personal history or family history of high temperature or death during exercise? **Yes No**

Have you required unusually large amounts of local anesthetic for medical or dental procedures? **Yes No**

Have you ever had a bad reaction to a local anesthetic (Novocain, etc)? **Yes No**

Are you allergic to adhesive tape? **Yes No**

Are you allergic to suture material such as catgut? **Yes No**

Do you have high blood pressure? **Yes No**

Have you ever had Scarlet Fever or Rheumatic Fever? **Yes No**

Do you bleed unusually easily (from cuts, surgery, tooth extractions)? **Yes No**

Do you bruise unusually easily? **Yes No**

Are you a slow or poor healed? **Yes No**

Do you form large scars or keloids? **Yes No**

Do you have any skin disease, hives, eczema or rash? **Yes No**

Do you have frequent infections or boils? **Yes No**

Have you taken steroid medications, cortisone, or ACTH? **Yes No**

Do you have shortness of breath with walking? **Yes No**

Does your religion prohibit blood transfusions? **Yes No**

Do you have, or have you had any significant emotional problems? **Yes No**

Have you ever had psychiatric care? **YesNo**

Have you ever been advised to see a Psychiatrist? **Yes No**

Have you ever had Herpes? **Yes No**

NOTICE TO MEDCAL CONSUMERS
Medical Doctors are licensed and regulated by the Medical Board of California
(800-633-2322) www.mbc.ca.go

I authorize Geoffrey R. Keyes, M.D. and office staff (admin assistant, clerical, management, etc.) to communicate with me by:

- ☐ Email (unencrypted email)
- ☐ Phone

This authorization will expire until patient states otherwise.

Signature: ___________________________________ Relationship to Patient: ____________________________

 P.T. #: ___________