Philadelphia
FACIAL PLASTIC SURGERY
& MEDSPA

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Philadelphia, PA 19123
www.phillyfacialsurgery.com

NEW PATIENT INTAKE FORM

DEMOGRAPHICS

Name: _____ Age: _____
Last First Middle

DOB:_____ SEX: _____

NAME YOU WISH TO BE CALLED:_____

Mailing Address:

_____
Street City State Zip

Mobile #: _____ Work #: _____ Home # _____

Email Address: _____

Preferred Method of Contact: ☐ Email ☐ Text ☐ Phone Call

Can we leave messages on the above contact method? ☐ YES ☐ NO

EMERGENCY CONTACT - In case of a medical emergency, who can we contact on your behalf?

Emergency Contact Person: _____
Relationship to You: _____
Phone: _____ Alternate Phone: _____

HEALTH INSURANCE INFO (Optional for purely cosmetic surgery patients)

Primary Insurance Company & Plan:_____
Policy holder's Name: _____ Relation to You: _____
Policy holder's DOB: _____
Insurance ID # _____ Group # _____

MARKETING INFO - How did you hear about us?

☐ Internet search (Google, etc.) ☐Facebook ☐Instagram ☐ RealSelf

☐ Referred by _____

☐ Other_____

FINANCIAL QUESTIONS

How do you plan to pay for your plastic surgery? ☐ Cash ☐ Credit card ☐Financing ☐ Insurance

If you plan to finance, do you have an account with:

Care Credit? ☐ YES ☐ NO Proceed ☐ YES ☐ NO

If you plan to finance, would you like us to start the process to secure financing? ☐ YES ☐ NO

MEDICAL INFORMATION

What is the purpose of your visit? What would you like to discuss with Dr. Spalla?

_____

_____

Have you had consultations with other plastic surgeons? ☐ YES ☐ NO

If Yes, who? _____

Are you seeing Dr. Spalla as a result of an accident, trauma, or assault? ☐ YES ☐ NO

Have you sought legal consultation for the reason you are seeing Dr. Spalla? ☐ YES ☐ NO

Are you seeing Dr. Spalla regarding a worker's compensation case? ☐ YES ☐ NO

MEDICATIONS

PLEASE INDICATE ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING (include herbal and OTC)

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

HAVE YOU HAD AN ADVERSE REACTION OR ALLERGY TO ANY MEDICATION? ☐ YES ☐ NO

If yes, please explain:

_____

HAVE YOU, OR A FAMILY MEMBER, HAD AN ADVERSE REACTION TO ANESTHESIA? ☐ YES ☐ NO

If yes, please explain:_____

HAVE YOU, OR A FAMILY MEMBER, EVER BEEN DIAGNOSED OR TREATED FOR A BLEEDING DISORDER? ☐ YES ☐ NO If yes, please explain: _____

PAST MEDICAL HISTORY

ANY ONGOING or PAST MEDICAL/PSYCHIATRIC DIAGNOSES DO YOU HAVE?

_____

_____

_____

PLEASE LIST ANY SURGERIES OR PROCEDURES THAT YOU HAVE HAD IN THE PAST, INCLUDING COSMETIC SURGERY

Type	Date	Type	Date
Type	Date	Type	Date
Type	Date	Type	Date

_____Have you ever had cancer (including skin cancer)? ☐ YES ☐ NO

If Yes, provide details:

_____

_____

FAMILY HISTORY – Please list any known medical conditions in your family

_____

_____

EDUCATION/EMPLOYMENT

Are you in school? ☐ YES ☐ NO

If Yes, what year/grade?_____

Are you working? ☐ YES ☐ NO

If Yes: ☐ Full-time ☐ Part-time

Occupation:_____

Does your job require physical exertion? ☐ YES ☐ NO

How much time are you allowed to take off of work to recover? _____

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
- Tinnitus 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/pain Y / N
- Palpitations Y / N

GASTROINTESTINAL
- Swallowing trouble 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

SKIN
- Rashes Y / N
- Lumps 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

ENDOCRINE
- Thyroid trouble Y / N
- Diabetes Y / N
- Hormonal imbalance 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 _____

FEMALE REPRODUCTIVE HISTORY

Age at 1st menstruation: _____ yo

Pregnancies: _____ # Live births: _____

Age of children (if any): _____

Age at menopause: _____ yo

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:

_____

_____

_____

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Partnered

Living Status: ☐ Alone or ☐ With whom_____

Do you have family or friends that can help you recover, if needed? ☐ YES ☐ NO

Status of nicotine Use (cigarettes, cigars, vaping, patches, smokeless):

☐ I have never used tobacco

☐ I currently use tobacco

Please elaborate what you use, frequency, and for how long_____

☐ I quit tobacco

When and how much and for how long did you use?_____

Do you drink alcohol? ☐ YES ☐ NO

If Yes, how much and how often?_____

Do you use any drugs (including marijuana)? ☐ YES ☐ NO

If Yes, what, how much and how often?_____