Elizabeth Clanton, MD Pediatric & Adult Plastic & Reconstructive Surgery

Medical Intake Form

Patient Name: _____ Date of Birth: _____

MEDICAL INFORMATION: TO THE BEST OF YOUR KNOWLEDGE, DO YOU HAVE/HAVE HAD:

1	Unexplained Weight Loss	Yes	No	32	Rash/Skin Changes	Yes	No
2	Chills/Fever/Sweats	Yes	No	33	Polio/Muscle Disease	Yes	No
3	Vision Changes	Yes	No	34	Artificial Joints	Yes	No
4	Hearing loss/ringing	Yes	No	35	Bleeding/Bruising	Yes	No
5	Nose bleeding/discharge	Yes	No	36	Breast mass/pain/discharge	Yes	No
6	Sores in mouth/bleeding gums	Yes	No	37	Lightheadedness/Dizziness	Yes	No
7	Sore throat/hoarseness	Yes	No	38	Migraine/Cluster Headaches	Yes	No
8	Painful swallowing	Yes	No	39	Seizures	Yes	No
9	High Blood Pressure	Yes	No	40	Spinal Cord Injury	Yes	No
10	Heart Disease Heart Attack	Yes	No	41	Traumatic Brain Injury	Yes	No
11	Chest Pains/ Angina	Yes	No	42	Chronic Headaches	Yes	No
12	High Cholesterol	Yes	No	43	Fibromyalgia	Yes	No
13	Pacemaker	Yes	No	44	Chronic Pain	Yes	No
14	Shortness of Breath	Yes	No	45	Night Pain	Yes	No
15	Asthma	Yes	No	46	Unexplained Pain	Yes	No
16	Allergies	Yes	No	47	Concussion	Yes	No
17	Chronic Bronchitis	Yes	No	48	Chronic Fatigue Syndrome	Yes	No
18	Emphysema	Yes	No	49	Depression	Yes	No
19	Swelling of Extremities	Yes	No	50	Anxiety/Panic Attacks	Yes	No
20	Hepatitis	Yes	No	51	Sleep Disorders	Yes	No
21	Ulcers	Yes	No	52	Thyroid Problems	Yes	No
22	Abdominal Pain	Yes	No	53	Diabetes	Yes	No
23	Blood in Stool/Ulcers	Yes	No	54	Hypoglycemia	Yes	No
24	Bowel Incontinence	Yes	No	55	HIV	Yes	No
25	Kidney Disease/Stones	Yes	No	56	Fainting Disorders	Yes	No
26	Bladder Incontinence	Yes	No	57	Blood Disorders	Yes	No
27	Blood in Urine	Yes	No	58	Anemia	Yes	No
28	Gynecological Disorders	Yes	No	59	Lyme's Disease	Yes	No
29	Are you pregnant?	Yes	No	60	Latex Sensitivity	Yes	No
30	Arthritis/Joint Pain	Yes	No	61	Cancer/Tumors/Growths	Yes	No
31	TMJ Disorders	Yes	No	62	Fractures	Yes	No

Current Condition: What brings you to our office today? _____

List any previous test or procedures performed for this problem (X-rays, MRI, CT Scans, U/S, Labs):

_____

CURRENT MEDICATIONS: _____

List any **FAMILY** medical history: _____

Are you **ALLERGIC** to any **MEDICATIONS? NO/YES,** if **YES** please list: _____

List **ALL** Surgeries include dates: Please use the other side of this paper, if needed.

SOCIAL HISTORY:

Occupation: _____ **Pregnancies: _____ LMP:**_____

Alcohol Consumption: YES NO How many drinks: _____ Daily Weekly Monthly

Do you smoke cigarettes, cigars, vape: YES NO Year started smoking: ____ Year quit: ___Cig/day:_____