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REGISTRATION FORM FOR PLASTIC AND RECONSTRUCTIVE SURGERY

TODAY'S DATE ____/____/____

LEGAL NAME _____

PREFERRED NAME _____ PRONOUNS (optional) _____

DATE OF BIRTH ____/____/____ AGE _____

LEGAL SEX: MALE _____ FEMALE _____ GENDER IDENTITY (optional): _____

MARITAL STATUS: SINGLE _____ MARRIED _____ WIDOWED _____ DIVORCED _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME # _____ WORK # _____ CELL # _____

E-MAIL _____

EMPLOYER _____

OCCUPATION _____

INSURANCE CARRIER _____

EMERGENCY CONTACT _____ PHONE # _____

WHO REFERED YOU TO THIS OFFICE? _____

IS THIS PERSON AT NORTHWESTERN MEDICAL GROUP? YES _____ NO _____

IF NO, WHAT IS HIS/HER NAME, ADDRESS AND TELEPHONE #

WHO IS YOUR PRIMARY CARE PHYSICIAN _____

PRIMARY PHYSICIAN'S ADDRESS _____ PHONE # _____

REASON FOR YOUR VISIT _____

TYPE OF INJURY: AUTO _____ WORKERS COMPENSATION _____ OTHER _____

WORKERS COMPENATATION CARRIER _____ PHONE # _____

PATIENT PREOPERATIVE HISTORY

LEGAL NAME _____ DATE OF BIRTH ____/____/____

PREFERRED NAME _____

PREFERRED DAYTIME PHONE # _____ PREFERRED LANGUAGE _____

PLANNED SURGERY _____

PRIMARY CARE PHYSICIAN _____ PCP PHONE # _____

PLEASE LIST ALL PREVIOUS SURGERIES (AND APPROXIMATE DATES)

PLEASE LIST ANY ALLERGIES TO MEDICATIONS, LATEX, FOOD OR OTHER (AND YOUR REACTIONS TO THEM)

LIST ALL MEDICATIONS (INCLUDE OVER-THE-COUNTER DRUGS, INHALERS, HERBAL SUPPLEMENTS AND ASPIRIN)

Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency

WEIGHT (LBS OR KG) _____

HEIGHT (INCHES OR CM) _____

PLEASE CHECK ANY THAT APPLY TO YOUR HEALTH:

- | | |
|---|---|
| <input type="checkbox"/> Heart attack at any time | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Heart attack within the past 60 days | <input type="checkbox"/> Murmur |
| <input type="checkbox"/> Chest pain or pressure with activity | <input type="checkbox"/> Valve disorder |
| <input type="checkbox"/> Angina | <input type="checkbox"/> LVAD |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Heart device |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Heart stent within the last 6 months | <input type="checkbox"/> Defibrillator |
| <input type="checkbox"/> Heart stent at any time | <input type="checkbox"/> Fainted in the last year |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Pain in legs while walking |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> None of these |
| <input type="checkbox"/> Congenital heart disease | |

- Unable to climb 2 flights of stairs or walking 2 blocks because of chest pain or trouble breathing**
- Oxygen at home**
- Pulmonary hypertension**
- Asthma**
- COPD**
- Trouble breathing at rest or with minimal exertions**
- Face, arm or leg weakness
- Stroke/TIA within past 3 months**
- Stroke or TIA at any time
- Paralysis
- Difficulty speaking
- Dementia**
- Parkinson's
- Myasthenia gravis**
- Hospitalized in last 30 days***
- Diabetes
- Cancer: _____***
- Chemo or radiation in last 3 months**
- Kidney disease other than stones***
- Liver disease**
- Cirrhosis**
- Lupus**
- Hepatitis B/C
- Jaundice**
- Hyperthyroidism**
- Hypothyroidism
- Blood thinners or anticoagulants other than aspirin**
- Bleeding with surgery or tooth extractions**
- Blood transfusion in last 3 months**
- Blood clots/Pulmonary embolus**
- Hemophilia**
- Von Willebrands**
- Known bleeding disorder**
- Malignant hyperthermia (in blood relatives or self) with anesthesia
- Difficult airway during anesthesia
- Severe nausea or vomiting from anesthesia**
- Unintentional weight loss >10 lbs.**
- Difficulty getting out of bed/chair on your own
- Difficulty making your own meals
- Your physical abilities limit your daily activities
- Difficulty doing your own shopping
- Very loud snoring
- Tired/fall asleep frequently during the day
- Observed to stop breathing during sleep
- High blood pressure/hypertension
- Sleep apnea; NO CPAP**
- Sleep apnea; USES CPAP
- None of these
- Pneumonia in last 2 months**
- Any problems with your lungs**
- Severe cough**
- None of these**
- Muscular dystrophy**
- Multiple sclerosis**
- Spinal cord injury**
- Brain tumor**
- Brain aneurysm or AVM**
- Epilepsy, blackouts or seizures**
- None of these
- Adrenal disorder**
- Pituitary disorder**
- Dialysis**
- Scleroderma**
- Rheumatoid arthritis**
- Sjogren's
- HIV**
- Use illegal drugs (excluding marijuana)**
- Kidney failure**
- Taking antibiotics for any reason
- None of these
- Jehovah's Witness/Refusal blood products**
- Sickle cell disease**
- Anemia**
- Severe nose bleeds
- None of these
- Dentures
- Problems opening your mouth
- Loose teeth
- None of these
- Feel that everything you did was an effort: _____ days in the last week
- Need assistance with eating, bathing or dressing**
- Fallen within the last 6 months: _____ times
- None of these
- Cannot speak and/or understand English
- Cannot lie flat for 45 minutes
- Currently pregnant. Last menstrual period: _____
- Smoker (current or past) _____ packs per day for _____ years. Quit date _____**
- Drinks alcohol. How much each day? _____ beers _____ glasses of wine _____ shots of hard alcohol

PLEASE LIST ANY MEDICAL ILLNESS OR MEDICATIONS NOT NOTED ALREADY:

BOLDED items indicate the need for an in person preoperative evaluation