SANDRA MARGOLES MD
AESTHETIC PLASTIC SURGERY

Patient Information

Please print and answer all questions completely. If any of this information changes in the future, please let the office know. Thank you.

Name_____ Today's Date _____

Street Address_____ City_____ State_____ Zip_____

Birth Date _____ Age ____ Social Security #_____ Sex ____M ___F

Phone Numbers: Home # _____Office #_____ Cell #_____

Email_____

Emergency Contact _____ Relationship to Patient _____ Phone _____

Name of Primary Care Doctor? _____Phone: _____

Reason for your visit today? _____

Who referred you to Dr. Margoles? _____

Are you employed? ____ Yes ____ No What is your usual occupation?_____

Insurance Information

Insurance 1_____ Policy Holder _____ Social Security #_____
Policy #_____Group # _____ Copay Amount _____

Employer responsible for insurance:_____ Phone _____
Address: _____

Do you have additional (secondary) insurance? Insurance 2: _____ Policy Holder _____
Policy #_____

I authorize release of any medical information necessary to process any insurance claims. I authorize payment of medical benefits directly to the physician or supplier of services for myself and/or dependents. I understand I am responsible for any deductibles, co-insurances, or amounts for services not covered by the insurance carrier. I also understand that it is my responsibility to obtain the necessary referrals for my visits and medical care, and to verify that my insurance is active and up to date. I also give consent to the taking of photographs for the medical record or teaching purposes, as long as the identity of the patient is not revealed. This authority shall remain outstanding until withdrawn in writing by the undersigned.

Signature _____ Date _____
(Patient or Guardian

Please check all or any that apply to you:

General

- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness

Skin

- ☐ Bleed or bruise easily
- ☐ Hives
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

Cardiovascular

- ☐ Chest pain
- ☐ Artificial heart valve
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Shortness of breath
- ☐ Swelling of ankles
- ☐ Varicose veins

Gastrointestinal

- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Hemorrhoids

Eye/Ear/Nose/Throat

- ☐ Blurred vision
- ☐ Dry eyes

Muscle/Joint/Bone

Pain, weakness or numbness in:

- ☐ Neck ☐ Arms ☐ Hand
- ☐ Back ☐ Legs ☐ Feet

Women Only

- ☐ Nipple discharge
- ☐ Breast lump

Date of last period:
___/___/___

Date of last mammogram:
___/___/___

Result:
☐ Normal ☐ Abnormal

Are you pregnant?
☐ Yes ☐ No

Planning to be pregnant?
☐ Yes ☐ No

Are you nursing?
☐ Yes ☐ No

Check conditions you have or had in the past:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Angina
- ☐ Anorexia
- ☐ Bleeding disorders
- ☐ Blood clot
- ☐ Breast lump
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Connective tissue disease
- ☐ Contact Lenses
- ☐ Dental appliances
- ☐ Diabetes
- ☐ Depression
- ☐ Glaucoma
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart mummer
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes/cold sore
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Keloid scar
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Multiple sclerosis
- ☐ Nervous breakdown
- ☐ Pacemaker
- ☐ Psychiatric care
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Tuberculosis

Please answer the following so that we may best take care of you:

Have you ever had a bad surgical result? ☐ Yes ☐ No

Have you or anyone in your family had an adverse reaction to anesthesia? ☐ Yes ☐ No

Does anyone in your family bleed easily? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No

Do you drink more than two alcoholic drinks in one day? ☐ Yes ☐ No

Signature _____ Date _____

Medical Information

Height _____ Weight _____

MEDICATIONS
List all medications, including over the counter and herbal supplements you are currently taking:

_____
_____
_____
_____

ALLERGIES
List all allergies to medication or substances, and their reactions:

_____
_____
_____
_____

MEDICAL CONDITIONS
List all medical conditions you have:

_____
_____
_____
_____

HOSPITALIZATIONS AND SURGERIES
List all hospitalizations and surgeries with dates and reasons:

_____
_____
_____
_____

I certify that I have read and understood the questions above. I acknowledge that my questions, if any about the above have been answered to my satisfaction. I will not hold my surgeon or any of her staff responsible for any errors or omissions that I have made in completing this Health Questionnaire.

I understand that I am here today for a consultation regarding cosmetic and/or reconstructive surgery with Dr. Sandra Margoles and I am in no way obligated to partake in any procedure without informed consent.

I give my permission for any medical information to be released to my insurance company to accompany any claims for services rendered if applicable.

Signature _____ Date _____