

MICHAEL J. SUNDINE, M.D., F.A.C.S., F.A.A.P.
Board Certified Plastic Surgeon
Facial Aesthetic-Cosmetic-Craniofacial Surgeon

Reason for Consultation _____ Date _____
(Facelift, Brow/Forehead Lift, Eyes, Nose, Breast Augmentation, Craniofacial Surgery, Hemangioma-Vascular Birthmark, etc)

Patient Information

Name _____ Date of Birth _____ Age _____
Mr. Mrs. Ms. Miss Dr.

Address _____ Home # () _____

City _____ State _____ Zip _____ Cell # () _____

E-Mail Address _____ Fax # () _____

May we email you specials/practice updates? _____ Yes No _____

Social Security # _____ Driver's License # _____

Employment Information

Employed by _____ Work # () _____

Business Address _____

City _____ State _____ Zip _____

Marital Status Married Single

Name _____ Cell # () _____

Employed by _____ Work # () _____

Business Address _____

City _____ State _____ Zip _____

Name and Address of Nearest Relative Not Living with You

Name _____ Relationship _____
Mr. Mrs. Ms. Miss Dr.

Address _____ Phone # () _____

City _____ State _____ Zip _____

Referral Information May we contact? Yes No

Referred by _____ Phone # () _____

Address _____

City _____ State _____ Zip _____

INSURANCE: PLEASE BRING CURRENT CARD AND COPAY WITH YOU TO YOUR CONSULTATION:

Name of Insurance Company _____ Phone () _____

Address _____ City, State _____

Zip _____ ID Information (Policy #, Group #, etc.) _____

Secondary Insurance _____

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL OF MY MEDICAL BILLS INCURRED, NOT MY INSURANCE COMPANY OR OTHER THIRD PARTY. I HEREBY AUTHORIZE MICHAEL J. SUNDINE, M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS OR OTHER THIRD PARTY AS APPROPRIATE CONCERNING THIS CONSULTATION OR FUTURE SERVICES. I HEREBY IRREVOCABLY ASSIGN TO MICHAEL J. SUNDINE, M.D. ALL PAYMENTS FOR MEDICAL SERVICE RENDERED, AND WILL FORWARD ANY PAYMENT MADE FOR DR. MICHAEL SUNDINE SERVICES DIRECTLY AND IMMEDIATELY TO HIS OFFICE. I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ Date _____

SIGNATURE OF FINANCIALLY RESPONSIBLE PARTY AND RELATIONSHIP TO PATIENT

WITNESS _____ Date _____ (

Copy Saved in File)

Primary Care Doctor _____ Phone # () _____

His/Her Address _____

City _____ State _____ Zip _____

Present Illness:

Description _____

Onset _____

Severity of the problem (Scale of 1-10) _____

Location initially, Sites of recurrence _____

Symptoms, preceding and associated _____

How long has the problem lasted? _____

Previous therapy _____

Past History:

Do you have any chronic medical problems?

Hypertension

Diabetes Mellitus

Cancer

Heart Disease

Kidney Disease

HIV or AIDS

Heart Failure

Seizures

Bleeding Problems

Heart Attack

Liver Disease

Stroke

Emphysema

Hepatitis

Ulcers

Asthma

High Cholesterol

Sleep Apnea

Deep Venous Thrombosis

Pulmonary Embolism

Other _____

Please list all prior operations:

Date

List any complications

1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Please list ALL medications you are taking, include over the counter medications (eg. Aspirin, Motrin, etc.), vitamins, and herbal remedies (Echinacea, Fish Oil, etc.).

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

List any allergies to medications and describe the reactions.

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Family History-Do you have any family history of medical problems?

Hypertension	Diabetes Mellitus	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Seizures	Bleeding Problems
Heart Attack	Liver Disease	Stroke
Emphysema	Hepatitis	Other _____

Social History-

Have you ever smoked cigarettes? _____ Yes _____ No. If yes, please state the year started _____

How many packs per day did (do) you smoke? _____

If you are a former smoker, state the year you stopped _____

Alcohol Consumption: Never _____ Rare _____ Moderate _____ Heavy _____

Did you ever drink heavily in the past? Yes _____ No _____

Do you ever use drugs? Yes _____ No _____ Type _____ Frequency _____

Occupation _____ Marital Status _____

Height: _____

Weight: _____

Review of Systems: Do you have any of the following conditions, illnesses, or symptoms?

General

Chills	Fevers	Loss of sleep
Weight loss	Sweats	

Eye, Ear, Nose, and Throat

Bleeding gums	Blurred vision	Crossed eyes
Difficulty swallowing	Double vision	Earache
Ear discharge	Hayfever	Hoarseness
Loss of hearing	Nosebleeds	Persistent cough
Ringing in ears	Sinus problems	Vision-flashes, halos

Cardiovascular

High blood pressure	Heart attack	Angina/chest pain
Irregular heart beat	Heart murmur	Heart failure
Pacemaker	Swelling of ankles	Varicose veins

Respiratory

Abnormal chest x-ray	Asthma	Bronchitis
Emphysema	Recent chest infection	Shortness of breath
Shortness of breath at night	Shortness of breath on exertion	Cough
Cough Cough with sputum	History of tuberculosis	

Gastrointestinal

Poor appetite	Bloating	Bowel changes
Constipation	Diarrhea	Excessive hunger
Excessive thirst	Gas	Heartburn
Hemorrhoids	Hepatitis	Hiatal hernia
Indigestion	Jaundice	Nausea
Rectal bleeding	Stomach pain	Ulcers
Vomiting	Vomiting blood	

Genitourinary

Blood in urine	Frequent urination	Lack of bladder control
Painful urination	History of kidney disease	History of urinary disease

Musculoskeletal

Arthritis	Rheumatoid arthritis	Herniated disc
Sciatica	Neck problems	Back problems
Leg problems	Arm problems	

Endocrine

Diabetes	Thyroid disease	Taken steroids
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Hematologic/Oncologic/Infectious

Bleeding tendency
Sickle cell disease
Radiation therapy

Easy bruising
Blood clots in legs

Anemia
Blood clots in lungs

Skin

Hives
Change in moles

Itching
Rash

Itching
Sores that won't heal

Neuropsychiatry

Stroke Seizures
Dizziness
Anxiety
Nervousness

Fainting
Headaches
Psychiatric care Forgetfulness
Numbness

Depression

MEN only

Breast lump
Penis discharge

Erection difficulties
Sore on penis

Lump in testicles
Other _____

WOMEN only

Abnormal Pap smear
Extreme menstrual pain
Painful intercourse

Bleeding between periods
Hot flashes
Vaginal discharge

Breast lump
Nipple discharge
Other _____

Date of last menstrual period _____

Number of pregnancies _____

Number of children _____

Did you breast feed? _____

Could you be pregnant? _____

Date of last mammogram _____

Date of last Pap smear _____