



Michael Workman, M.D.

Patient Physical & History Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**SOCIAL**

Age: \_\_\_\_\_ Sex: M  F  Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Married: Y  N

Occupation: \_\_\_\_\_

Responsible Adult Available to Assist During Recovery Period Y  N  Relationship: \_\_\_\_\_

**HABITS**

Smoke: Y  N  Amount: \_\_\_\_\_ Coffee/Tea/Cola: Y  N  Amount: \_\_\_\_\_

Alcohol: Y  N  Amount: \_\_\_\_\_ Daily Exercise: Y  N  Amount: \_\_\_\_\_

**MEDICATIONS:** List dose or number of pills per day

Prescription Drugs

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Non Prescription (Vitamins: Herbs)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Regular Aspirin Use: Y  N  Dosage & Frequency \_\_\_\_\_

NSA (Advil, Motrin, Ibuprofen): Y  N  Dosage & Frequency \_\_\_\_\_

Cortisone Injections Past Year: Y  N  Dosage & Frequency \_\_\_\_\_

Drug Allergy: Y  N  List drug(s) and type of reaction: \_\_\_\_\_

Latex Allergy: Y  N

Tape Allergy: Y  N

**FAMILY HISTORY:** Have any blood relatives ever had the following problems:

Abnormal Bleeding: Y  N  Coronary Surgery: Y  N  Kidney Disease: Y  N

Abnormal Clotting: Y  N  Diabetes: Y  N  Tuberculosis: Y  N

Anesthetic Problems: Y  N  Heart Attack: Y  N  Other Serious Illness: Y  N

Cancer: Y  N  Hypertension: Y  N

Please describe questions with a "Yes" answer: \_\_\_\_\_

**PERSONAL PAST HISTORY:** Have you ever had:

Abnormal Bleeding: Y  N  Asthma: Y  N  Hypertension: Y  N

Abnormal Clotting: Y  N  Diabetes: Y  N  Sleep Apnea: Y  N

Acid Regurgitation: Y  N  Fainting Spell: Y  N  Snoring: Y  N

Anemia: Y  N  Heart Attack: Y  N  Weight Change past 12 Mo: Y  N

Angina: Y  N  Hepatitis: Y  N  Other Serious Illness: Y  N

DVT/Blood Clots: Y  N

Please describe questions with a "Yes" answer: \_\_\_\_\_

Have you ever had a transfusion? Y  N  If yes, what year: \_\_\_\_\_

Have you been tested for HIV? Y  N  If yes, what year? \_\_\_\_\_ Test results:  Positive  Negative

Do you wear: Contact lenses: Y  N  Eye Glasses: Y  N  Hearing aids: Y  N  Dentures: Y  N

Previous Surgery, year and type of procedure: \_\_\_\_\_

Indicate the type(s) of anesthesia received in the past, list any complication / reactions you experienced:

Local anesthesia – (complications/reactions): \_\_\_\_\_

General anesthesia – (complications/reactions): \_\_\_\_\_

Spinal / Epidural – (complications/reactions): \_\_\_\_\_

Date last seen by Primary Care Physician: \_\_\_\_\_

Primary Care Physician (name) \_\_\_\_\_ (telephone) (\_\_\_\_\_) \_\_\_\_\_

**WOMEN PATIENTS ONLY**

Number of pregnancies \_\_\_\_\_ Number of children \_\_\_\_\_ Last menstrual period \_\_\_\_\_ Did you breast feed? Y  N

\_\_\_\_\_  
**PATIENT'S SIGNATURE**

\_\_\_\_\_  
**DATE**

Initial: \_\_\_\_\_ Date: \_\_\_\_\_



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**PATIENT REGISTRATION FORM**

Name: \_\_\_\_\_  
Last First Middle

Previous Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Mailing Address Apt. # City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birth date: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

May we call you at home? Yes \_\_\_\_\_ No \_\_\_\_\_ May we call you at work? Yes \_\_\_\_\_ No \_\_\_\_\_

Is it OK to leave you a message? Home? Yes \_\_\_\_\_ No \_\_\_\_\_ Work? Yes \_\_\_\_\_ No \_\_\_\_\_

What source was most influential in your decision to visit our office? \_\_\_\_\_

Portland Dex Yellow Pages, Vancouver Dex Yellow Pages, Verizon Yellow Pages, Oregonian, Columbian, Portland Monthly, Breast Implants 411, Website (please specify website), Seminar, Friend, Physician Referral or Reference

What was the second most influential source in your decision to visit our office? \_\_\_\_\_

Other: \_\_\_\_\_

Would you like to receive our Plastic Surgery Newsletter via email? Yes \_\_\_\_\_ No \_\_\_\_\_

Email address: \_\_\_\_\_

EMERGENCY INFORMATION: (Name of friend or relative who could be reached in case of emergency)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_