MEDICAL HISTORY FORM
Please Complete in Entirety

Name: _____ Today's Date:_____

Age: ____ Sex: M / F Height: _____ Weight: _____(Is your weight stable? YES NO)

Which hand do you write and perform most tasks with: RIGHT / LEFT

Why are you here to see Dr. Geiger?_____

Are you interested in any cosmetic procedures? ie Botox, Fillers, Skin Care or Surgery

Please list ALL medications that you currently take including vitamins and over the counter medications (continue on back of form if necessary):

Name	**Dosage**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS:

YES NO Have you ever taken weight reduction (diet) pills?
YES NO Do you take aspirin, Plavix, Coumadin or any other blood thinner?

Are you allergic to any **medications**? YES NO

If yes, please list all medications that you are allergic to and REACTION:_____
(examples: penicillin, sulfa drugs, clindamycin, doxycycline, vancomycin, codeine, Percocet, morphine)

Are you allergic to **Latex?** YES NO
If yes what reaction?
_____

History of MRSA YES NO

Last Flu vaccine _____

Pnemonia Vaccine _____
Falls in past Year _____

Please list ALL current and prior medical conditions/diagnosis: (continue on back of form if necessary):_____
_____
_____
_____
_____

Please list all prior surgical procedures: (continue on back of form if necessary)

_____

Have you ever had a problem with general anesthesia? YES NO

FAMILY HISTORY: Diabetes Stroke Heart Disease Aneurysm Cancer Keloid Scarring NONE
If so, please describe:
_____
_____

WOMEN:
Number of pregnancies: _____ Births: _____ C-sections: _____ Miscarriages: _____

YES NO Are you pregnant or trying to become pregnant? Age of first period? _____
YES NO Do you have problems associated with your menstrual period?
YES NO Are you nursing?
YES NO Are you taking birth control pills? Age of menopause?_____
YES NO Urinary Incontinence?

Date of last mammogram? _____ Have you ever had an *abnormal* mammogram? YES NO

SOCIAL HISTORY:
Do you smoke? YES / NO. If yes, how many packs per day? _____ How many years have you been smoking? _____ Prior Smoking Quit Date _____

Do you drink alcohol? YES / NO Estimated # of drinks per average week? _____

Do you use any street drugs (will be kept confidential. May have interactions with anesthesia)? YES / NO Please list drug, frequency, last use
_____
Do you exercise regularly? YES / NO Type: Weight training, running, elliptical, bike, swim?

Employed: YES / NO. Occupation _____
If no, when was your last work day? _____ Any current work restrictions?
_____

REVIEW OF SYSTEMS: Please circle any symptoms you have had *in the past 6 months* unless otherwise noted:

Constitutional:
Fevers, night sweats, recent weight gain (# of lbs _____), recent weight loss (# of lbs_____)

Eyes: Loss of vision, blurry vision, double vision, dry/irritated eyes, watery eyes.
Do you wear glasses? YES / NO Do you wear contacts? YES / NO

Ears: Deformity, drainage, change in hearing

Nose: Seasonal allergies/congestion, sinus disease, nose bleeds

Mouth: Difficulties swallowing
Have you *ever* had a cold sore/fever blister? YES / NO
Do you take antibiotics for dental procedures? YES / NO

Respiratory: Frequent coughs, shortness of breath on exertion, shortness of breath at rest, wheezing

Cardiovascular: Chest pain, palpitations/heart racing, swollen ankles

Breast: Masses, lumps, nipple discharge, pain, abnormal mammogram

Musculoskeletal: arthritis, extremity pain, extremity weakness

Neurologic: inability to move muscles of face, numbness in face, numbness of finger(s), numbness of toe(s)

Skin: Rash, itching, new lesion, change in skin color, drainage from skin
Personal history of keloid/hypertrophic/aggressive scarring? YES / NO
Personal history of poor wound healing? YES / NO

Hematologic: Easy bleeding or bruising, history of blood clot/DVT

Lymphatic: Swelling in neck, armpit, groin. Swelling in ankles

Endocrine: Diabetes, thyroid problems

Psychological: Feelings of anxiety, depression

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Signature: _____ **Date**: _____

Parent or Guardian's Signature: _____ **Date**: _____

Reviewed by Dr. Geiger: _____ **Date:** _____

Chesterfield Plastic & Reconstructive Surgery — Patient Data Sheet

Referred by _____ Primary Care Physician _____

Patient _____

Address _____

City, State, Zip _____

Home Phone No. _____ Cell Phone No _____ Work Phone No _____

*May we leave a message? **Y** **N*** *May we leave a message? **Y** **N*** *May we leave a message? **Y** **N***

Date of Birth _____ Sex: **M** **F** Marital Status: **Single** **Married** **Widowed** **Divorced** **Separated**

SSN _____ Patient's Employer _____

Employment Status **Full Time** **Part Time** **Retired** **Unemployed** Student Status: **Full Time** **Part Time** **N/A**

Emergency Contact _____ Phone No. _____ Rel. To Patient _____

Person Responsible for Balance _____ Responsible Party's Date of Birth _____

Responsible Party's Address _____ SSN _____

Email Address _____

We are collecting email addresses for those patients that would like to use myStLukes Patient Portal for our office to communicate with you via the Web.

Race: (*Please Circle*)

American Indian or Alaska Native
Asian
Native Hawaiian
Black or African America
White
Hispanic
Other Race
Other Pacific Islander
Unreported/Refused to Report

Ethnicity: Hispanic Non-Hispanic Refused to Report **Preferred Language:** _____

Pharmacy: ❑ Local Pharmacy Name_____ Local Pharmacy Telephone No._____

❑ Mail Order Pharmacy Name_____ Mail Order Pharmacy Telephone No._____

INSURANCE INFORMATION (COPIES OF INSURANCE CARDS REQUIRED)

Primary Insurance _____ Effective Date _____

Name of Insured/Subscriber _____ Relationship to Patient _____

Insured's Date of Birth _____ Insured's I.D. No. _____ Group No. _____

Secondary Insurance _____ Effective Date _____

Name of Insured/Subscriber _____ Relationship to Patient

Insured's Date of Birth _____ Insured's I.D. No. _____ Group No. _____

ASSIGNMENT OF INSURANCE INFORMATION & BENEFITS/RELEASE OF MEDICAL INFORMATION: I hereby authorize this St. Luke's Medical Group physician to administer / perform any treatment deemed necessary, and authorize release of information needed to secure payment. I authorize that all benefits by my insurance company be paid directly to St. Luke's Medical Group, and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. In addition, I hereby authorize the release of all applicable medical information including & without limitation copies of all records and test results produced to the designated attending, referral, and/or follow-up physicians and such other health care practitioners or organizations who/which will be providing subsequent monitoring of care or treatment in connection with care provided by the St. Luke's Medical Group

Signature of Responsible Party _____ Date _____

Acknowledgement of Privacy Practice and Patient Rights

1. Patient Rights: A copy of my Patient Rights has been made available to me.
2. Notice of Privacy Practice: A copy of St. Luke's Hospital Notice of Privacy Practice has been made available to me.

_____ _____ _____

Signature of Patient (or Legal Guardian/Representative) **Date** **Relationship to Patient**

❑ Patient unwilling or unable to sign acknowledgement **Reason**:_____

Chesterfield Plastic & Reconstructive Surgery Patient Data Sheet

e-Prescribing Consent

ePrescibing is defined as a Physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that that ability to electronically send prescriptions is an important element in improving the quality of Patient care. ePrescribing greatly reduces medication errors and enhances Patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe Program. These include:

- ❑ Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- ❑ Medication history transactions – Provides the physician with information about medications the Patient is already taking to minimize the number of adverse drug events.
- ❑ Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the Patient's prescription has been picked up, not picked, or partially filled.

By signing this consent form you are agreeing that (Practice Name) can request and use your prescription medication history from other healthcare Providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to (Practice Name) to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name: _____ Patient DOB: _____

Signature of Patient or Guardian: _____ Date: _____

Relationship to Patient: _____

E-Messaging Services

Please note: Our Practice sends appointment reminder notifications to our patient's using an electronic reminder system through our Electronic Health Records. Please indicate how and when you would like to receive these alerts.

Method of Communication	Preferred Time to Call
❑ **Home Phone** ❑ **Work Phone** ❑ **Cell Phone (Phone Call)** ❑ **Cell Phone (Text MSG)**	❑ **AM (8am-12pm)** ❑ **Afternoon (12-4pm)** ❑ **PM (4-9pm)**

Please list all individuals that we may communicate with regarding your medical information

❑ Declined

Name: _____ **Relationship:** _____ **Phone #:** _____

Name: _____ **Relationship:** _____ **Phone #:** _____

Name: _____ **Relationship:** _____ **Phone #:** _____

St. Luke's MEDICAL GROUP

Chesterfield Plastic and Reconstructive Surgery, LLC
Scott E. Geiger, M.D.
111 St. Luke's Center Drive, Suite #46B
Chesterfield, MO 63017

Authorization for Patient Photographs and Releases

Patient Name _____

Address _____
(street address, city, state and zip code)

I, _____, hereby authorize Scott E. Geiger, M.D., and/or his representative(s) to take photographs or videotapes of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Geiger. I understand that such images shall become the property of Dr. Geiger for medical purposes to be used for my care.

In addition, I would like to authorize the use of these images, without compensation to me, for the following specific purposes: (Please **initial** in the boxes marked Yes or No for *each* item)

YES	NO	Imaging Media
		In office photo album for prospective patients.
		In office seminars for prospective patients
		Print in medical journal or textbook, or electronic use as part of scientific presentation or teaching course to other medical professionals.
		On our website for prospective patients (before and after photos)

I understand my defined authorization(s) above allows use and/or release by Scott E. Geiger, M.D. for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals, textbooks, or Web sites for the purpose of informing the medical profession or the general public about his plastic surgery procedures and methods.

I will not be identified by name in any of the imaging media described above. However, I also understand that in some circumstances the photographs, slides, or videotapes may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Geiger.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, and I understand it will not have any effect on any actions taken prior to my revocation. If I choose to revoke this authorization I will do so in writing to Scott E. Geiger, M.D. at the above listed address.

Patient Initials_____

St. Luke's MEDICAL GROUP

Chesterfield Plastic and Reconstructive Surgery, LLC
Scott E. Geiger, M.D.
111 St. Luke's Center Drive, Suite #46B
Chesterfield, MO 63017

Authorization for Patient Photographs and Releases

I understand that the information disclosed under this Authorization, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

I release and discharge Dr. Geiger and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____
Signature Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of_____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date