**St. Luke's Medical Group** **Patient Data Sheet**

Patient Legal Name: ______________________ Patient Preferred Name: ______________________

Address: ______________________________________________

City, State, Zip: ______________________________________________

Home Phone: ______________ *May we leave a message? Y N* Cell Phone: ______________ *May we leave a message? Y N* Work Phone: ______________ *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: ______________ Rel. To Patient: ______________

Person Responsible for Balance: ______________________ Responsible Party's DOB: ______________

Responsible Party's Address: ______________________________

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.***

Referred by: ______________________ Primary Care Provider: ______________________

<u>Race: (*Please Circle*)</u>

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

<u>Ethnicity:</u> Hispanic Non-Hispanic Refused to Report <u>Preferred Language:</u> ______________________

<u>Pharmacy:</u>

❑ Local Pharmacy Name______________________ Local Pharmacy Telephone No.______________

❑ Mail Order Pharmacy Name______________________ Mail Order Pharmacy Telephone No.______________

<u>E-Messaging Services</u>

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 |
|---|
| ❑Home Phone |
| ❑Work Phone |
| ❑Cell Phone (Phone Call) |
| ❑Cell Phone (Text MSG) |
| ❑Email |

Chesterfield
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## Missed or Cancelled Appointments

**Please provide at least 24 hours' notice to cancel or reschedule an appointment.** When we make an appointment for a patient, we reserve that time only for them. If the patient cannot make their appointment, please let us know as soon as possible. With notice of at least 24 hours, the patient will not be charged a cancellation fee. The sooner the patient calls us, the greater our chances of providing this time to someone else.

**Missed appointments or cancellations within 24 hours will incur a $30.00 fee.** If the patient fails to show for an appointment or does not provide at least 24 hours' notice before cancelling, we will consider this to be a no showed appointment and we may charge the patient $30.00. This charge will be billed to the patient directly and not to their insurance provider.

## Late Appointment Arrivals

**If you arrive more than 15 minutes late for your appointment, we may ask you to reschedule, and this will also be considered a no show appointment.** We offer a designated appointment time for each patient and ask that you arrive on time. It may be necessary to arrive early to complete paperwork, process insurance, or address your questions regarding procedures. If you arrive late or for any other reason (e.g. incomplete paperwork, insurance complications) are delayed more than 15 minutes beyond your appointment time, you may be asked to reschedule for another day.

Your cooperation with these policies helps us to provide the best care possible for you and our other patients. Thank you.

Print Name: ____________________________________________

Signature Patient/Guardian: ________________________________

Date: ______________________________

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## 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 to be seen?**

______________________________________________

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

## MEDICATIONS:

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 |
| --- | --- | --- |
| | | |
| | | |
| | | |
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| | | |
| | | |
| | | |
| | | |

Have you ever taken weight reduction (diet) pills? YES NO

Do you take aspirin, Plavix, Coumadin or any other blood thinner? YES NO

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

If yes, please list all medications that you are allergic to and the **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

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**FAMILY HISTORY:** ____Diabetes ____Stroke ____Heart Disease ____Aneurysm

____ Cancer ____Keloid Scarring ____NONE

If yes, please describe & note relation:______________________________________________

**WOMEN:**
Number of pregnancies: ____ Births: ____ C-sections: ____ Miscarriages: ____

YES NO Are you pregnant or trying to become pregnant?
YES NO Do you have problems associated with your menstrual cycle?
YES NO Are you nursing?
YES NO Are you taking birth control pills?
YES NO Urinary Incontinence?

Age of first period? ________
Age of menopause? ________

Date of last mammogram? ______________________

Have you ever had an *abnormal* mammogram? YES NO

**SOCIAL HISTORY:**

**Do you smoke?** ______ If yes, how many packs per day? ________

How many years have you been smoking? ________ Prior Smoking Quit Date ________

**Do you vape?** ________ If yes, how often? __________

**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? ___________

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## 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:** ____________

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## Authorization for Patient Photographs and Releases

I, ______________________________, hereby authorize Chesterfield Plastic & Reconstructive Surgery, LLC and/or the representative(s) to take photographs or video of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Chesterfield Plastic & Reconstructive Surgery, LLC. I understand that such images shall become the property of Chesterfield Plastic & Reconstructive Surgery, LLC.

In addition, I 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 | |
|---|---|---|
| ☐ | ☐ | On our website for prospective patients (before and after photos). |
| ☐ | ☐ | Print in medical journal or textbook, or electronic use as part of scientific presentation or teaching course to other medical professionals. |
| ☐ | ☐ | On social media as an education and promotional tool for prospective patients. |

**For CoolSculpting Patients Only:**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Photography may be released to ZELITIQ Aesthetics, Inc. ("ZELTIQ") and may be used for print, visual or electronic media including, but not limited to, scientific presentations, websites, general marketing and for purposes of informing the medical profession or general public, about the CoolSculpting procedure on behalf of ZELTIQ. These images may be published by the physicians, ZELTIQ and their agents and representatives. |

I will not be identified by name in any of the imaging media described above. However, I also understand that in some circumstances the images or video may portray features that will make my identity recognizable (e.g. your facial features will be visible for facial surgery, but not for breast/body surgery).

I further understand that I have the right to revoke or refuse 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 Chesterfield Plastic & Reconstructive Surgery, LLC at the above listed address.

______________________________ ______________________________

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