Office of William P. Adams, Jr., M.D. Medical History Form

Please help us assure you the highest quality care by answering carefully

Demographic Information

Today's Date _____

Last Name: _____ First _____ MI _____ Date of Birth: _____

Address: _____ Apt. _____ City/ ST: _____ Zip: _____

Home: _____ Cell: _____ Do you authorize our office to send texts? ☐ Yes ☐ No

Email Address: _____ Do you authorize our office to send emails? ☐ Yes ☐ No

Social Security: _____ (optional – for implant tracking and/ or study purposes)

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced

Occupation: _____ Is your job physically demanding? ☐ Yes ☐ No

Spouses Name: _____ Phone Number: _____

Emergency Contact Name, Phone Number, & Relationship:

_____

Who may we thank for your referral? _____

What procedure(s) would you like to discuss? _____

Preferred Pharmacy: _____ Phone Number: _____

** Authorization to discuss protected information: i.e. spouse, significant other, etc.

Name: _____ Relationship: _____ Phone Number: _____

***** Please be advised that any person not listed above will not be given any information related to your care, including billing information. You may make changes to this listing at anytime.

Allergies and Reactions

☐ None

Medication(s): _____ Reaction: _____

Tape: _____ Reaction: _____

Personal Health Habits

Have you or do you use any type of nicotine products? ☐ Y ☐ N How many per day or when did you quit? _____

Do you consume alcohol? ☐ Y ☐ N If yes, how many beverages? _____ ☐ Weekly ☐ Monthly

Current Medications, Herbs & Vitamins

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

7)_____ 8)_____ 9)_____

Do you use any non-prescription medications or drugs that are not listed above? ☐ Y ☐ N

If yes, please list: _____

Do you use any diet medication: ☐ Y ☐ N If yes, please list: _____

Breast & Body

Height:_____ Weight: _____ Are you within 10lbs of your goal weight? ☐ Y ☐ N

How many total pregnancies? _____ How many total deliveries? _____ Please list ages of your children: _____

Date of last menstrual cycle: _____

Please answer the questions below ONLY if breast surgery is going to be discussed: Did you breast feed? ☐ Y ☐ N

In most bras, please list what cup size: Current bra size? _____ Most common bra manufacturer:_____

What is your preferred cup size? _____ Bra size prior to first pregnancy? _____

What is the largest bra size including during pregnancy or breastfeeding? _____

Have you had any type of breast disease? ☐ Y ☐ N If yes, please explain: _____

Have you had a breast biopsy? ☐ Y ☐ N What were the results? _____

Do you have family history of breast cancer? ☐ Y ☐ N If yes, who in your family was diagnosed? _____

Have you had a mammogram in the past year? ☐ Y ☐ N If yes, what were the results? _____

What was the date of the last mammogram? _____ What facility? _____

Patient Health History

Please answer YES or NO if you have or have had the following:	YES	NO		YES	NO
Prolonged bleeding when cut	☐	☐	Thyroid problems	☐	☐
High blood pressure	☐	☐	Rheumatic fever	☐	☐
Heart disease/or heart attack	☐	☐	Cancer	☐	☐
Heart murmur	☐	☐	Immune disorders	☐	☐
Heart valve disorder	☐	☐	Kidney problems	☐	☐
Irregular heart beats/palpitations	☐	☐	Fainting or blackout episodes	☐	☐
Blood disorder (anemia, etc.)	☐	☐	Shortness of breath	☐	☐
Diabetes	☐	☐	Lung/respiratory problems	☐	☐
Ulcer disease	☐	☐	Swelling of the ankles	☐	☐
Herpes/ fever blisters	☐	☐	Skin disorders	☐	☐
Hepatitis	☐	☐	Eyes: burning, itching, redness	☐	☐

If you have answered yes to any of the above please explain:	

Past Surgical History

Please list all surgeries including date or year that you have had in the past:

Surgery: _____ Date or Year: _____

Surgery: _____ Date or Year: _____

Surgery: _____ Date or Year: _____

Surgery: _____ Date or Year: _____

Surgery: _____ Date or Year: _____

Surgery: _____ Date or Year: _____

Have you or anyone in your family had a reaction to general anesthesia?	

Have you formed excessive or unsatisfactory scars in the past?	☐ Y ☐ N	Location(s)	

I _____ authorize William P. Adams, Jr., M.D. PA, to charge my account in the amount of $80 for the consultation fee. The amount is non-refundable within 72 hours of the scheduled appointment or no show.

Signature: _____ Date:_____