PLASTIC SURGERY GROUP
OF ROCHESTER

ROCHESTER
HAND
CENTER

Jeffrey A. Fink, MD • Andrew W. Smith, MD, FACS • Brian D. Kubiak, MD, FACS •David Refermat, MD, FACS
Julie Sylvester, RPA-C

Patient Name: _____ Date: _____

Address: _____ Date of Birth: _____

City: _____State:_____ Zip: _____Sex: M F Other_____Age:_____

Marital Status: M S W D **Phone**: (Home) _____(Work)_____ (Cell)_____

Race:White / African American / American Indian /Alaska Native/ Asian/ Native Hawaiian/ Other Pacific Islander
Other / Declined

Ethnicity: Hispanic/ Non-Hispanic Declined_____

Preferred Language: English Other_____ Declined

Employer: _____ Occupation: _____

Employer's Address: _____

Spouse/Partner or Parent/Guardian Name: _____ Relationship _____Phone_____

Primary Care Physician: _____

Referring physician/person who sent you: _____

INSURANCE INFORMATION *******Copays are due at the time of service*******

Primary: Name of Insurance Co.: _____ Insurance ID#:_____

Subscriber's Name:_____ Subscriber's Birthdate: _____

Subscriber's Employer:_____ Relationship: _____

Secondary: Name of Insurance Co.: _____ Insurance ID#:_____

Subscriber's Name:_____ Subscriber's Birthdate: _____

Subscriber's Employer:_____ Relationship: _____

Were you treated in the Emergency Room/Urgent Care Center for this condition: Yes No
If yes which Hospital or Urgent Care Center: _____
Is this a work-related injury: Yes No
Does this visit relate to a motor vehicle accident: Yes No

www.rochesterplasticsurgery.com

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Permission Regarding Communications

Please check the following as you wish and sign at the bottom of the page:

Leave information regarding appointments:

answering machine	____
cell phone/text	____
office voice mail	____
w/ another person	____
send through mail	____
send via e-mail/Portal	____

Leave other medical info on:

answering machine	____
cell phone/text	____
office voice mail	____
w/ another person	____
send through mail	____
send via e-mail/Portal	____

E-mail address:_____

As a patient, you may choose whether to allow us to communicate information about your health status with the persons you list below. If you do not wish information about your health care to be shared with another individual, you do not have to complete this section.

I, _____, give permission to the Plastic Surgery Group of
(please print your name here)
Rochester to discuss information regarding my health with the following individuals:

Name of individual: _____

Telephone number: _____

Relationship to patient: _____

Name of individual: _____

Telephone number: _____

Relationship to patient: _____

Please sign Electronic Signature at Front Desk

THE PLASTIC SURGERY GROUP OF ROCHESTER, LLC

Please answer all questions below to the best of your knowledge. The information provided by you will be used by your doctor in decisions regarding your care. This information will not be released without a written authorization from you.

Which hand do you write with (please circle) Left Right

Reason for today's visit: _____

DO YOU NOW HAVE, OR HAVE YOU HAD: (if yes check the space provided.)

General
- Unexplained weight loss _____
- Unexplained fever _____
- Other_____

Cardiac
- High blood pressure _____
- Heart failure _____
- Heart attack _____
- Mitral valve prolapse _____
- Other heart murmur _____
- High cholesterol _____
- Angina _____
- Peripheral vascular disease _____

Pulmonary
- Tuberculosis _____
- Emphysema _____
- Asthma _____

Endocrine
- Diabetes _____
- Diabetes (taking insulin) _____
- Thyroid disorder _____

Neurological
- Stroke _____
- Seizures _____

Musculoskeletel
- Arthritis _____
- Tendonitis _____
  where_____

Other
- Cancer _____
  where_____
- Leukemia _____
- Bleeding tendency _____
- HIV/AIDS _____
- Stomach ulcers _____
- Hepatitis A, B, or C _____
  (please circle A,B, or C, above)
- Depression _____
- Anxiety _____
- Other(Please List) _____
  _____
  _____

Pharmacy:_____

List all medications and dosages: _____

_____ _____

_____ _____

List allergies to any medications: _____

LATEX ALLERGY ?Yes No

Do you have allergies to anything else?_____

List **all** operations you have had: _____

_____

List other serious injuries/accidents you have had: _____

SOCIAL HISTORY

Do you smoke now? No_____ Yes_____How much?_____How long?_____
Did you smoke in the past? No_____Yes_____How much?_____For how long?_____
When did you quit?_____
Do you regularly drink (circle) alcohol, beer, or wine? No_____Yes_____ How much?_____

HEIGHT_____ WEIGHT _____

Woman only: Any chance you are pregnant? No_____ Yes_____ EDD_____
Have you had a mammogram? No_____ Yes_____
If yes-date/location_____

Name:_____**DOB:**_____

REVIEW OF SYSTEMS

In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed.

Const. (Health in General) ❑ No Problems; Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems; Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems; Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ❑ No Problems; Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ❑ No Problems; Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ❑ No Problems; Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems; Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integ. (Skin, Hair & Breast) ❑ No Problems; Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems; Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems; Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑ No Problems; Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems; Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems; Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

Has any family member ever had: (Father, mother, sister, brother)

	Yes	No	Relationship		Yes	No	Relationship
Cancer				Diabetes			
Kidney Disease				Thyroid Disease			
Heart Disease				Seizure Disorder			
High Blood Pressure				Stroke			
Arthritis				High Cholesterol			
Stomach Disease				Asthma			
Tuberculosis				Drug/Alcohol Abuse			

Above information has been reviewed with patient.

Doctor:_____ Date/Time:_____