FROST PLASTIC SURGERY
look good. feel great.

Name_____ Age_____

Phone: Home_____ Work_____ SSN_____

E-mail Address_____ May we add you to our e-mail list?_____

Primary Insurance_____ Secondary Insurance_____

Whom may we thank for referring you to Dr. Frost?_____
Who is your primary physician? _____
Reason for Visit_____

MEDICAL HISTORY Have you ever been treated for any of the following:

YES		Please Explain
_____	Diabetes	_____
_____	High Blood Pressure	_____
_____	Heart Disease	_____
_____	Heart Attack	_____
_____	Stroke	_____
_____	Lung Disease	_____
_____	Kidney Disease	_____
_____	Arthritis	_____
_____	Mental Illness	_____
_____	AIDS, HIV, Hepatitis	_____
_____	Other	_____

SURGICAL HISTORY Please list all surgeries you have had with approximate date

_____
_____
_____
_____
_____

BREAST HISTORY If you are being seen for breast surgery, please complete this section

Bra Size_____ Last Mammogram_____
_____Personal History of Breast Cancer _____

_____Family History of Breast Cancer_____

MEDICATIONS Please list all medications you take including aspirin and herbs

_____
_____
_____
_____

ALLERGIES Please list any allergies to medications or check "None"

_____None List_____
_____Latex _____

PERSONAL HISTORY

Height_____ Weight_____ Preferred Weight_____
Marital Status: Single_____ Married_____ Divorced_____ Widowed_____
Do you Smoke?_____ How Much?_____
How much alcohol do you drink?_____
Type of work_____

SIGNATURE_____
Today's Date_____