

**RICHARD A. D'AMICO, M.D.**

**DATE** \_\_\_\_\_

CONFIDENTIAL PATIENT INFORMATION  
(complete all items, please print)

PATIENT'S NAME \_\_\_\_\_

(LAST) (FIRST) (MI)  
PATIENT'S SS# \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE# \_\_\_\_\_ BUSINESS PHONE# \_\_\_\_\_ EXT. \_\_\_\_\_ CELL: \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

MARRIED \_\_\_\_\_ SINGLE \_\_\_\_\_ WIDOWED \_\_\_\_\_ DIVORCED \_\_\_\_\_ SEPARATED \_\_\_\_\_

NAME OF SPOUSE or legal guardian if minor) \_\_\_\_\_

SPOUSE OR GUARDIAN'S EMPLOYER \_\_\_\_\_  
ADDRESS \_\_\_\_\_

NEAREST RELATIVE AND ADDRESS: \_\_\_\_\_

**PATIENT REFERRED BY:**  
\_\_ ASAPS \_\_ ASPS \_\_ IMPLANT INFO.COM \_\_ NY MAGAZINE TOP DOC \_\_ OTHER \_\_\_\_\_

HAS DR. D'AMICO CONSULTED OR TREATED ANY FAMILY MEMBER? \_\_\_\_\_  
IF YES, WHOM? \_\_\_\_\_

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**SPECIFIC PROBLEM FOR WHICH YOU ARE SEEKING PLASTIC SURGERY:**

HAVE YOU CONSULTED OTHER PHYSICIANS INCLUDING PLASTIC SURGEONS ABOUT THIS? \_\_\_\_\_  
IF YES, DOCTOR'S NAME \_\_\_\_\_

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**INSURANCE INFORMATION**

NAME OF INSURED \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_

ID# \_\_\_\_\_ POLICY # \_\_\_\_\_ GRP# \_\_\_\_\_ CO-PAY \_\_\_\_\_

IF GROUP INSURANCE, COMPANY NAME OF EMPLOYER \_\_\_\_\_

**PERSON FINANCIALLY RESPONSIBLE:** Patient ( ) Parent ( ) Other ( ) Relationship \_\_\_\_\_ SS# \_\_\_\_\_

NAME \_\_\_\_\_ DOB \_\_\_\_\_ Telephone # \_\_\_\_\_

(party financially responsible)

ADDRESS \_\_\_\_\_

EMPLOYER \_\_\_\_\_ Telephone # \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

**PAST MEDICAL HISTORY**

GENERAL HEALTH: GOOD \_\_\_ FAIR \_\_\_ POOR \_\_\_ IF NOT "GOOD", PLEASE EXPLAIN:

HEIGHT \_\_\_ WEIGHT \_\_\_ WEIGHT LOSS/GAIN IN PAST YEAR \_\_\_ LBS LOSS GAIN

NAMES ADDRESSES AND TELEPHONE NUMBERS OF TREATING PHYSICIANS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WHEN WAS YOUR LAST MAMMOGRAM? \_\_\_\_\_

HOW LONG AGO WAS YOUR MOST RECENT PHYSICAL CHECK-UP? \_\_\_\_\_

DID IT INCLUDE AN ELECTROCARDIOGRAM? NO \_\_\_ YES \_\_\_

CHEST X-RAY? NO \_\_\_ YES \_\_\_

HAVE YOU EVER HAD AN ECHOCARDIOGRAM? NO \_\_\_ YES \_\_\_

A CARDIAC ULTRASOUND? NO \_\_\_ YES \_\_\_

A STRESS TEST? NO \_\_\_ YES \_\_\_

ARE YOU, OR COULD YOU BE, PREGNANT? \_\_\_\_\_

WHEN WAS THE DATE OF YOUR LAST MENSTRUAL PERIOD? \_\_\_\_\_

**SERIOUS ILLNESSES** (Please list) \_\_\_\_\_

Have you had any illnesses or disorders of the following? (Circle if YES)

Face (paralysis)  
(Including Strokes, Epilepsy)

Heart or Blood Vessels  
(MVP or heart/valve, Scarlet  
or Rheumatic Fever)

Blood

High blood  
pressure

Brain

Nervous System  
(Including Paralysis, Numbness)

Nose, Sinuses, Throat

Stomach

Urinary System

Bones or Joints

Eyes  
(Including Glaucoma, Dryness)

Breasts

Intestines

Reproduction  
System

Endocrine System  
or Diabetes

Ears

Lungs  
(Including Asthma)

Liver  
(Hepatitis)

Arms or Legs

If circled, please explain: \_\_\_\_\_

**BLEEDING/CLOTTING HISTORY**

Have you had any bleeding or clotting disorders?

(e.g. Thrombosis, pulmonary emboli?)

Yes \_\_\_ No \_\_\_

Do you bruise spontaneously?

Yes \_\_\_ No \_\_\_

Have you ever been told by a doctor that you have a bleeding or bruising problem? Yes \_\_\_ No \_\_\_

**PREVIOUS SURGERY (Please list)**

Operations	Year	Hospital	City	Surgeon's Names	Anesthesia(Local or General)

HAVE YOU HAD SIGNIFICANT COMPLICATIONS OR AFTER EFFECTS FROM ANY OF THESE OPERATIONS? NO \_\_\_ YES \_\_\_

IF "YES", PLEASE EXPLAIN \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INJURIES**

Type	Year	Hospital	Doctor	After-Effects

**FAMILY HISTORY**

Age	State of Health	Has any relative had:
Mother _____		Cancer.....No ___ Yes ___
Father _____		Diabetes.....No ___ Yes ___
Brother(s) _____		Heart Disease.....No ___ Yes ___
Sister(s) _____		High Blood Pressure.....No ___ Yes ___
Children _____		Lung Disease.....No ___ Yes ___
_____		Blood or Bleeding Disorders.....No ___ Yes ___
_____		Asthma.....No ___ Yes ___
_____		Mental Illness.....No ___ Yes ___
_____		Muscular Dystrophy.....No ___ Yes ___
_____		Malignant Hyperthermia.....No ___ Yes ___

**MEDICATIONS, DRUGS**

What is your approximate daily consumption of the following:

Coffee or Tea \_\_\_\_\_ Alcohol \_\_\_\_\_ Tobacco \_\_\_\_\_

Other intoxicating or mind altering drugs (specify) \_\_\_\_\_

Does anyone else in your household smoke? No \_\_\_ Yes \_\_\_ How much? \_\_\_\_\_

PLEASE LIST ALL YOUR MEDICATIONS AND THEIR DOSAGES (INCLUDING BIRTH CONTROL PILLS, DIURETICS (WATER PILLS) BLOOD PRESSURE OR HEART MEDICATIONS, TRANQUILIZERS, HORMONES, BLOOD THINNERS, NOSE DROPS AND SPRAYS, INHALER MEDICINES, RUB-ON MEDICATIONS (LINIMENTS), ASPIRIN, BUFFERIN, ETC.):

\_\_\_\_\_  
\_\_\_\_\_

**PERTINENT PREOPERATIVE INFORMATION**

Are you allergic to any medications? No \_\_\_\_\_ Yes \_\_\_\_\_  
If "Yes", which one(s)? \_\_\_\_\_

Do you have any food allergies? No \_\_\_\_\_ Yes \_\_\_\_\_  
If "Yes", which one(s)? \_\_\_\_\_

Have you ever reacted badly to being put to sleep for surgery? \_\_\_\_\_ No\_\_ Yes\_\_

Has any member of your family ever reacted badly to being put to sleep for surgery? \_\_\_\_\_ No\_\_ Yes\_\_

Have you required unusually large amounts of local anesthetic for medical/dental procedures? No\_\_ Yes\_\_

Have you ever had a bad reaction to a local anesthetic (Novocain, etc.)? \_\_\_\_\_ No\_\_ Yes\_\_

Are you allergic to adhesive tape? \_\_\_\_\_ No\_\_ Yes\_\_

Are you allergic to suture material such as catgut? \_\_\_\_\_ No\_\_ Yes\_\_

Are you a slow or poor healer? \_\_\_\_\_ No\_\_ Yes\_\_

Do you form large scars or keloids? \_\_\_\_\_ No\_\_ Yes\_\_

Do you have skin diseases, hives, eczema or rash? \_\_\_\_\_ No\_\_ Yes\_\_

Do you have frequent infections or boils? \_\_\_\_\_ No\_\_ Yes\_\_

Have you taken steroid medications, cortisone or ACTH? If so, how long ago? \_\_\_\_\_ No\_\_ Yes\_\_

Have you taken Accutane? \_\_\_\_\_ When? \_\_\_\_\_ No\_\_ Yes\_\_

Have you ever been on Phen Phen, ephedrine or other weight loss reduction products? No\_\_ Yes\_\_

Do you have shortness of breath with walking? \_\_\_\_\_ No\_\_ Yes\_\_

Do you have, or have you had, any back trouble? \_\_\_\_\_ No\_\_ Yes\_\_

Have you ever been tested for HIV(AIDS)? If yes, positive or negative? \_\_\_\_\_ No\_\_ Yes\_\_

Have you ever tested positive for Hepatitis? \_\_\_(A, B, or C) \_\_\_\_\_ No\_\_ Yes\_\_

Have you ever had an outbreak of Herpes? \_\_\_\_\_ No\_\_ Yes\_\_

Does your religion prohibit blood transfusions? \_\_\_\_\_ No\_\_ Yes\_\_

Do you have, or have you had, any significant emotional problems? \_\_\_\_\_ No\_\_ Yes\_\_

Have you ever had, currently in, or been advised to seek psychotherapy or psychiatric care? No\_\_ Yes\_\_

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Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

PRINT NAME \_\_\_\_\_ Date: \_\_\_\_\_