MAIN LINE INSTITUTE of PLASTIC SURGERY

RYAN S. HOFFMAN, MD, FACS
Board Certified Plastic Surgeon

**PATIENT INFORMATION SHEET**

Date: _____

Legal Name (Last, First)_____Preferred Name_____

Address (**street, city, state, zip**): _____/_____/_____/_____

Primary Phone Number: _____ _____ Date of Birth: _____

E-mail Address: _____ SS#: _____

Primary insurance: _____ Are you the subscriber? ☐ Yes ☐ No

If no, relationship to subscriber: _____ Subscriber's DOB: _____

Subscriber's full name: _____ Subscriber's sex: ☐ M ☐ F ☐ T

Preferred Pharmacy (Name, address, & phone number): _____

Family Physician: _____Referring Physician: _____
(First name, Last name, Phone #) (First name, Last name, Phone #)

Do we have permission to speak with this person if necessary regarding your medical consultation? ☐ Yes ☐ No

Employer name: _____ Marital Status: _____

Race (circle one): American Indian / Asian / African American / Caucasian / Hispanic / Other: _____

Preferred Language (circle one): English / Indian / Spanish / Russian / Other: _____

Emergency Contact Information:

| Name | Relationship | Phone Number |
|---|---|---|
| | | |

Reason for today's visit: _____ Date of onset: _____

Please list all **medications** you are now taking and their **dosages** (including birth control pills, diuretics (water pills), blood pressure medications, tranquilizers, hormones, blood thinners, aspirin, bufferin, "recreational drugs", etc.)

| Medication | Dosage | Medication | Dosage |
|---|---|---|---|
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |
| 4. | | 8. | |

Do you have an Advance Directive? (living will) ☐ **Yes** ☐ **No**

Next side →

100 E Lancaster Avenue Suite 660, MOBE Wynnewood, PA 19096
email: hoffmanr@mlhs.org web: www.mainlinePS.com phone: 610-896-6666 fax: 610-896-6669

Any medical problems? ☐ **Yes** ☐ **No** If so, please list: _____

_____

Female patients: Are you currently pregnant or breastfeeding? ☐ **Yes** ☐ **No**

Are you allergic to any medications? ☐ **Yes** ☐ **No** If yes, which one(s)? _____

If yes, please describe your allergy or reaction: _____

Previous Surgery (please list)
Date (Mo/Year) Operation Hospital City Surgeon Anesthesia (Local/General)

_____

_____

☐ **Check this box if you have not had any previous surgeries**

Previous Hospitalizations (other than for surgery)
Date (Mo/Year) Reason

_____

_____

☐ **Check this box if you have not had any previous hospitalizations**

Family History:

| | Year of Birth | Living | Dead | Cause of Death | Major Diseases/Conditions |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Sister(s) | | | | | |
| Brother(s) | | | | | |
| Daughter(s) | | | | | |
| Son(s) | | | | | |

Social History:
☐ Current smoker Number of cigarettes smoked per day: ☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more
☐ Former smoker
☐ Non-smoker

Alcohol Consumption in Past Year:
☐ Never ☐ Monthly or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more times/week
Typical Amount of Drinks per Occasion:
☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more ☐ N/A

Height: _____ Weight: _____
Immunizations: Flu shot: yes/no, Approx Date:_____/ Pneumonia Yes/No, Approx Date:_____

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FOR OFFICE USE ONLY:

☐ SCD ☐ INP