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 →

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:_____________

FOR OFFICE USE ONLY:

☐ SCD ☐ INP