Scripps Clinic

Plastic and Reconstructive Surgery

We appreciate you taking the time to provide information on any medical conditions or changes relevant to your care with our surgeons.

Patient Sticker

New Patient Intake Form

General Information

Reason for consultation today? _____

Who referred you? _____

How did you learn about our office? _____

Current height? _____ Current weight? _____

What is your current occupation? _____

In reference to the REASON FOR CONSULT TODAY, please list any relevant surgeries you may have had in the past:

_____ Month/ Year_____

_____ Month/ Year_____

_____ Month/ Year_____

_____ Month/ Year_____

Are you currently taking any of the following medications? (Please circle all that apply)

Aspirin	Motrin	Aleve	Ibuprofen
Celebrex	Coumadin/ Warfarin	Eliquis	Xarelto
Plavix	Any additional blood thinners (please list) _____		

Social History (Please circle)

Do you use tobacco/ Nicotine products?	Yes	No	If yes, how much? _____
Do you drink alcohol?	Yes	No	If yes, how much? _____
Do you use recreational drugs?	Yes	No	If yes, what kind & how often? _____
Marital Status	Single	Married	
Do you have any Children?	Yes	No	Ages? _____
Does anyone currently live at home with you?	Yes	No	If yes, who? _____

Female Patients:

Are you currently pregnant?	Yes	No	If yes, how many weeks? _____
Have you ever had a mammogram?	Yes	No	If yes, when? _____

If you are interested in breast surgery, what is your current breast and cup size? _____

Please complete both sides →

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Review of systems

Do you have any medical problems in the following areas? (Please circle yes or no).

Yes / No **Neurologic** (seizures, paralysis). If yes, please explain_____

Yes / No **Eyes**. If yes, please explain_____

Yes / No **Ears, Nose, Throat**. If yes, please explain_____

Yes / No **Thyroid or Immune System**. If yes, please explain_____

Yes / No **Lungs or Breathing Problems**. If yes, please explain_____

Yes / No **Heart**. If yes, please explain_____

Yes / No **Blood Pressure or Blood Vessels**. If yes, please explain_____

Yes / No **Bleeding Problems**. If yes, please explain_____

Yes / No **Digestive Tract (Stomach, Bowels)**. If yes, please explain_____

Yes / No **Liver (Jaundice, Cirrhosis)**. If yes, please explain_____

Yes / No **Bone or Joint (Arthritis)**. If yes, please explain_____

Yes / No **Muscular (Weakness, Fatigue)**. If yes, please explain_____

Yes / No **Kidneys, Bladder, Urine**. If yes, please explain_____

Yes / No **Reproductive Organs**. If yes, please explain_____

Yes / No **Skin (Rash, poor wound healing, abnormal scars)**. If yes, please explain_____

Yes / No **Mental Illness (Anxiety, Depression)**. If yes, please explain_____

Is there anything else you would like your surgeon to know?

_____

_____

New Patient Intake Form

For Office Use Only

Vital Signs BP_____ P_____ RR_____ Temp_____

Right **Left**