Todd M. Gerlach M.D.
RECONSTRUCTIVE AND PLASTIC SURGERY

REGISTRY INFORMATION FOR CASE HISTORY

TO OUR COSMETIC PATIENTS: **DATE:_____**

Personal Information

Patient:_____ Date of Birth:_____ Age:_____

Address:_____ City:_____ Zip Code:_____

Home #:(____) _____-_____ Cell #:(____) _____-_____ Email:_____

Place of Employment:_____ Occupation:_____

Business Address:_____ City:_____ Zip Code:_____

Social Security #:_____

Spouse Information

(Please Circle)

Marital Status: S M D O Spouse Name:_____ Contact #:(____) ____-_____

Place of Employment:_____ Business #:_____

Business Address:_____ City:_____ Zip Code:_____

Insurance Information

Health Insurance:_____ Business #:(___) _____

Subscriber/Insured:_____ I.D. #:_____ Grp #:_____

Family Doctor:_____ Address:_____

City:_____ Zip Code:_____ Phone #: (____) _____-_____

Referred By:_____

In Case of Emergency-Notify:_____ Contact#:(___) _____-_____

Note: If patient is a minor – give name of person legally responsible:

Name:_____ Contact #: (____) _____-_____

WHAT ARE WE SEEING YOU FOR TODAY? _____

Health History

Do you take aspirin? Mg:_____ How often:_____..... No___ Yes___
Do you smoke? How Much:_____ How Long:_____..... No___ Yes___
Anemia ..... No___ Yes___
Skin Disease? What Kind:_____ ..... No___ Yes___
Hives, Eczema, or Rash..... No___ Yes___
Frequent Infections or Boils ..... No___ Yes___
Keloids..... No___ Yes___
Eye Disease..... No___ Yes___
Asthma..... No___ Yes___
When you get an open wound, does it take long to heal?..... No___ Yes___
Shortness of breath while walking?..... No___ Yes___
Have you ever had psychiatric care?..... No___ Yes___
Have you ever been advised to see a psychiatrist?..... No___ Yes___
Has there been any recent severe emotional upheaval in your life?..... No___ Yes___
Do you consider yourself nervous or depressed now?..... No___ Yes___
Has anyone ever had difficulty drawing blood from your veins?..... No___ Yes___
Are you allergic to any foods or drugs?..... No___ Yes___

To your knowledge have you ever had any of the following conditions:

AIDS	**Heart Disease**	**Jaundice**	**Blood Clotting Disorder**
Anemia	**Hemophilia**	**Rheumatic Fever**	**High Blood Pressure**
Cancer	**Hepatitis**	**Stroke**	**Mitral Valve Prolapse**
Diabetes	**HIV Positive**	**Tuberculosis**	

IF YES to any of the above, do you still have any residual effect from it?

_____

Are you ALLERGIC to any medications? NO YES If yes, which?

_____

List any medications you are presently taking on a regular basis, whether prescribed by a physician or not:_____

Are you pregnant? NO YES Date of last menstrual period:_____
Have you ever had a surgical operation? NO YES
If yes, please list below with approximate dates:_____
Any complications with previous surgery? NO YES
If yes Explain:_____
Are you presently being treated or observed by a physician for any health problems? NO YES
If yes, Physician's name:_____
Do you ever use: Marijuana, PCP, Cocaine, Heroine, or any other street drugs? NO YES
Have you ever been told by a physician or dentist that you're a bleeder? NO YES
Have you ever had any difficulty with: Local Anesthesia NO YES General Anesthesia NO YES
Have you ever had what seemed to be excessive bleeding following a cut, operation, or tooth extraction? NO YES

Please Sign:_____