Joseph K. Ku, M.D.
Cosmetic, Plastic and Reconstructive Surgery

In order for our office to best prepare for your visit, please complete the information below
and bring this form with you on the day of your consultation.

PATIENT INFORMATION

Confidential Information: The information herein will not be released except when you have authorized us to do so. This information will be used by the doctors in their decisions regarding your care.

Today's date: ____

Patient's Name: ____

Parent or Guardian's Name (for minors): ____

Address:____

City: ____________________ **State:** ________________________ **Zip:**________________

Telephone Numbers: Home: ____________ **Cellular:** __________ **Work:**_____________

E-mail address: ________________ **please check: okay to use please do not use**

Date of Birth: _________ **Age:** ___ **Height:** ____**Weight:** _____ Male Female

Marital Status: Single Married Widowed Divorced Separated

Social Security Number: _____-____-_____

Emergency Contact Name: __________________________________

Telephone: Home: _____________Cellular: ______________Work: ________________

Employer (if patient is a minor, parent's place of employment):___________________________

Employer Address: _______________________Telephone:__________________

Referring Physician (or source of reference): ____

Physician Address: ____________________________Telephone:_________________ ______

Family Physician's Name: ____

Address: _______________________Telephone: _____________________________________

Do you have Medical Insurance? o Yes o No (If yes please fill out the insurance information below)

Primary Insurance Carrier: ___________________________________

Name of Subscriber: _______________________________________

Please provide the front desk your Insurance Card for copying.

Precision Plastic Surgery

Your health is of extreme importance to us. The more we know about you, the better we can assist you.

Please complete the information on the following pages as completely as possible

What brings you to our office? Please be as specific as possible.

____

____

How long has this concerned you? ______________________________

Have you had any previous treatment for this? ______________________________

If YES, how and when was this treated? ______________________________

Review of systems:

Do you have or have you had any of the following? *(Please check yes or no)*

	YES NO		YES NO
AIDS or HIV positive	o o	Hepatitis	o o
Anemia	o o	High blood pressure	o o
Arthritis	o o	Irregular heart beat	o o
Asthma	o o	Kidney problems	o o
Back problems	o o	Migraine headaches	o o
Blood clots in legs	o o	Nervous breakdown	o o
Blood disorders	o o	Nose/throat problems	o o
Bleeding problems	o o	Pneumonia	o o
Breathing problems	o o	Psychiatric condition	o o
Cancer	o o	Rheumatic fever	o o
Chest pains	o o	Seizures	o o
Colitis	o o	Shortness of breath	o o
Diabetes	o o	Skin cancer	o o
Ear/eye problems	o o	Stomach problems	o o
Epilepsy	o o	Stroke	o o
Heart problems	o o	Thyroid problems	o o
Heart murmur	o o	Tuberculosis	o o
Heart palpitations	o o	Transfusion	o o

Past, Family and/or Social History:

List any hospitalizations and/or previous surgery, including dates:

____

____

Are you allergic to or have you ever had a reaction to any medication or drug; local anesthetic; or general anesthetic? If so, please list medication and type of reaction:

____

____

Precision Plastic Surgery

Are you now or have you ever taken any medications regularly (aspirin, birth control pills, herbs, vitamins, etc.)? Currently taking:

____

____

Previously taken:

____

____

Do you wear contact lenses? ____

Do you have problems with dry eyes? ____________________________________

Do you use wetting drops? ____

If so, how often, and for how long have you been using them? _____________________

Are you now or have you ever taken a prescription or over-the-counter medication for allergies, stuffiness, difficulty breathing, sinus problems or other nasal problems? If so, please list:

____

Do you currently smoke? o Yes o No
If yes, how many packs per day? ____________ **How many years?** ____________

Have you ever smoked? o Yes o No
If yes, how many packs per day____________ **How many years?** ____________

Do you drink alcohol? o Yes o No
If yes, how much? ______________________ **How often?** _________________

Do you have any relatives who have had breast cancer? o Yes o No
If yes, who?

____

____

Have you ever had a mammogram? o Yes o No
If yes, when was your last one? ______________________________________

Are you on Birth Control pills o Yes o No
If you are on birth control pills, and you elect to have surgery, we will require you to be off the pills for certain cases.

Have you had exposure to any of the following:

Radiation: o Yes o No

Excessive sun: o Yes o No

Do you or a member of your family have difficulty with prolonged bleeding when cut? o Yes o No

Do you or a member of your family bruise easily? o Yes o No

Do you have a problem with excessive scarring or keloid formation after being cut? o Yes o No

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Have you or a member of your family ever had a problem with
anesthesia? o Yes o No

Is your general health good? o Yes o No

Have you ever had psychiatric problems, a nervous breakdown or
been under the care of a psychiatrist, psychologist or mental health counselor?
o Yes o No

How did you learn about us? *(Please check all statements that apply.)*

o My friend, ____________________________________, told me about Dr. Ku.
o My doctor, ____________________________________, referred me to this office.
o Your location is convenient to my home or office.
o I visited your web site.
Web site name: ____
o Used search engine: **Google MSN Yahoo Other**:_________________________________
Keyword searched ____
o Referred by another site: ____

Thank you for taking the time to complete this information.
Please remember to bring this form with you on the day of your visit.