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J. Dan Metcalf, M.D.

PLEASE PRINT

NEW PATIENT INFORMATION SHEET

DATE____________________

NAME____
LAST NAME FIRST NAME INITIAL

ADDRESS____

CITY_____________________________STATE___________________ZIP_____________

HOME PHONE________________________WORK PHONE__________________________

CELL PHONE_________________________PHARMACY PHONE ______________________

EMAIL ADDRESS____

PLACE OF EMPLOYMENT____

TYPE OF WORK_________________________________SEX____________

AGE__________BIRTHDATE____________MARITAL STATUS___S___M___D___W

SOCIAL SECURITY #____________________DRIVERS LICENSE #________________

SPOUSES NAME____

REFERRED BY:____

PERSON TO CONTACT IN EVENT OF EMERGENCY:

NAME____

ADDRESS____

PHONE NUMBER____________________________________

MEDICAL HISTORY

Please circle correct responses or fill in the blanks where applicable

NAME________________________________AGE_____________BIRTHDATE_______________

HEIGHT___________FT.______IN.   WEIGHT_____________LBS.

CURRENT BRA SIZE__________________CUP SIZE DESIRED___________________

 # OF CHILDREN_____________________ AGE OF CHILDREN___________________

ARE YOU PREGNANT? Yes No   DATE OF LAST MENSTRUAL PERIOD_____________

ALLERGIES TO MEDICATIONS____

MEDICATIONS & DOSAGE TAKEN
REGULARLY____

PRESENT OR PREVIOUS MEDICAL ILLNESSES____

PREVIOUS
OPERATIONS____DATE____________________

____DATE_____________________

____DATE_____________________

COMPLICATIONS WITH PREVIOUS OPERATIONS OR ANESTHESIA?____________________
If so, explain)____

DO YOU OR FAMILY MEMBERS HAVE THE FOLLOWING? (Please circle)

Heart trouble   Excessive Bleeding Tendencies   Tuberculosis   High Blood Pressure

Diabetes   Excessive Bruisability   Breast Cancer   Asthma   Thyroid Problems

Excessive Scarring Psychiatric Problems   Other__________________________________

DO YOU OR HAVE YOU EVER HAD THE FOLLOWING? (Answer yes or no)

Fibrocystic changes of the breast?__________
Blood Pressure related problems________________
Liver, Gallbladder trouble, Yellow Jaundice or Hepatitis?_________
Diabetes?_________________
Epilepsy, Convulsions or Seizures?___________
Back Trouble______________________________
Abnormal Electrocardiogram (ECG)?____________

Heart trouble___________________________
Have you had a mammogram?___________When?_______________
Hiatal Hernia?____________
Kidney Disease?__________
Bleeding Tendencies?______________
Thyroid Problems?___________
Abnormal Chest X-Ray__________
Any recent medical/dental infections?______________________
Any other illnesses?____________ Explain____

DO YOU…….
Wear contact lenses?____________ Smoke_______________ How much?_____________________

SIGNATURE____DATE___________________________