John B. Fasano, MD

Plastic & Reconstructive Surgery

Last Name:_____ First Name:_____ M:_____

Address:_____ City:_____ State:_____ Zip:_____

SS Number:_____ Sex:_____ Date oF Birth: _____ Age:_____

Home Phone:_____ Cell Phone:_____ E-mail:_____

Work Phone:_____ Ext:_____ Occupation:_____

Where can we leave a message? Home:_____ Work**:**_____ Cell**:**_____ Marital Status: S_____ M_____ D_____ W_____

Who referred you to us? _____

Emergency Contact: _____ Phone:_____

My cosmetic consultation is for: _____

Height _____ Weight _____

Drug allergies?_____ If yes, please list:_____

Daily Intake: Tobacco_____ Alcohol _____ Aspirin_____ Insulin_____ Steroids_____

List medications, vitamins, & herbs taken on a daily basis:_____

_____

Medical History:_____

_____

_____

Please check if you have any of the following: Diabetes_____ Hypertension_____ Hepatitis_____

Mitral Valve Prolapse_____ Prolonged Bleeding_____ Artificial Joints_____ History of MRSA_____

List all operations and year: _____

_____

Have you or anyone in your family had a bad reaction to a local or general anesthetic? What type of reaction did you or they experience? _____

Who is your primary physician?_____ Phone:_____

Breast consultation patient's only: Bra Size_____ Date of last mammogram _____

Any family history of breast problems? _____

I understand that I am financially responsible for any outside laboratory or pathology services. There will be a service charge for any returned check. I consent to consultation and treatment by Dr, John B. Fasano, and agree to cooperate with the doctor in my care until completely discharged. I hereby authorize the release of any pertinent medical information regarding services rendered. I further authorize physician peer review of my medical record.

Patient Signature:_____ Date:_____