David M. Butler, M.D., F. A. C. S.
American Board of Facial Plastic and Reconstructive Surgery

NEW PATIENT HISTORY FORM

NAME:_____ **DATE:**_____

- Please answer all of the following questions to the best of your ability.
- Please write N/A if the question is NOT applicable to you.
- You may write on the other side of the form if any of your answers do not fit in the space given.

Clinician Notes

Principal Concern: What is the reason for this appointment?_____

_____

History of Present Illness (onset and any treatments leading up to the present time):

_____

_____

Any associated trauma or illness?_____

_____

Any associated symptoms?, (eg.pain, nerve dysfunction , visual impairment, etc.)

_____

Past Medical History

List medical conditions you are/have been treated for (high blood pressure, heart disease,diabetes, etc.)

_____

_____

List of medicines you are taking: 1._____ 2._____

3._____ 4._____ 5._____

List previous surgeries (including cosmetic treatments, procedures)

_____

This is page 1 of 2 - continue on the back

Clinician Notes

List drug allergies:_____

_____

Latex Allergy:_____

Social History

Your occupation:_____

Do you smoke/chew tobacco?_____ How much?_____

Do you drink alcohol?_____ How much?_____

Family History

Please list illnesses that run in your family:_____

_____

Bleeding disorders or anesthetic reactions?_____

REVIEW OF SYSTEMS:	NO	YES	REVIEW OF SYSTEMS:	NO	YES
Fevers or night sweats			Prostate Problems		
Nasal obstruction			Kidney Disease		
Bleeding tendency			Heartburn		
Asthma			Arthritis		
Diabetes			Vision Problems		
Seizures			Depression/Anxiety (please indicate which)		

If "YES" to any of the above, please give additional information below.

Who referred you to the office today?_____

Their address:_____

_____

Patient Use for Additional Information

Thank you for completing this form