

**GEOFFREY R. KEYES, M.D.**

**CASE HISTORY FILE**

Date: \_\_\_\_\_

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_  Married  Single  Widowed  Divorced  Separated

Cell Phone \_\_\_\_\_ Patient's Employer: \_\_\_\_\_

Business Phone \_\_\_\_\_ Patient's Occupation: \_\_\_\_\_

Email Address \_\_\_\_\_ @ \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Drivers License#: \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Spouse's Contact #: \_\_\_\_\_

Patient referred by:  INTERNET (  NASALSURGERY.ORG  KEYCARE.COM  GOOGLE  ASPS.COM )

INFOMERCIAL  NEWSPAPER/MAGAZINE  FRIEND: \_\_\_\_\_

M.D. REFERRAL: \_\_\_\_\_  OTHER: \_\_\_\_\_

Nearest Relative: \_\_\_\_\_ Nearest Relative's Phone # \_\_\_\_\_

*(not living at same address as patient)*

**INSURANCE INFORMATION**  COPY OF CARD GIVEN TO OFFICE

Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Social Security No. of Policy Holder: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**PERSON FINANCIALLY RESPONSIBLE** :  SELF  OTHER

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ CELL  OTHER: \_\_\_\_\_

**PRESENT PROBLEM**

Specific problem(s) for which you are seeking plastic surgery. \_\_\_\_\_ PRIMARY / REVISION

Have you consulted any other doctors, including plastic surgeons, about this? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please list their names \_\_\_\_\_



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**FAMILY HISTORY**

| <b>HAS ANY RELATIVE EVER HAD:</b> |   |   | <b><u>AGE</u></b> | <b><u>STATE OF HEALTH</u></b> |
|-----------------------------------|---|---|-------------------|-------------------------------|
| Tuberculosis                      | Y | N | Father _____      | Good / Fair / Poor            |
| Cancer                            | Y | N | Mother _____      | Good / Fair / Poor            |
| Epilepsy                          | Y | N | Brother(s) _____  | Good / Fair / Poor            |
| Heart Disease                     | Y | N | _____             | Good / Fair / Poor            |
| Mental Disease                    | Y | N | Sister(s) _____   | Good / Fair / Poor            |
| Lung Disease                      | Y | N | _____             | Good / Fair / Poor            |
| Kidney Disease                    | Y | N | Children _____    | Good / Fair / Poor            |
| Blood Disorders                   | Y | N | _____             | Good / Fair / Poor            |
| High Blood Pressure               | Y | N | _____             | Good / Fair / Poor            |
| Asthma/Breathing                  | Y | N | _____             | Good / Fair / Poor            |

**IMPORTANT PREOPERATIVE INFORMATION**

- Have you ever reacted badly to being put to sleep for surgery? **Yes No**
- Has any member of your family ever reacted badly to being put to sleep for surgery? **Yes No**
- Have you required unusually large amounts of local anesthetic for medical or dental procedures? **Yes No**
- Have you ever had a bad reaction to a local anesthetic (Novocain, etc)? **Yes No**
- Are you allergic to adhesive tape? **Yes No**
- Are you allergic to suture material such as catgut? **Yes No**
- Do you have high blood pressure? **Yes No**
- Have you ever had Scarlet Fever or Rheumatic Fever? **Yes No**
- Do you bleed unusually easily (from cuts, surgery, tooth extractions)? **Yes No**
- Do you bruise unusually easily? **Yes No**
- Are you a slow or poor healed? **Yes No**
- Do you form large scars or keloids? **Yes No**
- Do you have any skin disease, hives, eczema or rash? **Yes No**
- Do you have frequent infections or boils? **Yes No**
- Have you taken steroid medications, cortisone, or ACTH? **Yes No**
- Do you have shortness of breath with walking? **Yes No**
- Does your religion prohibit blood transfusions? **Yes No**
- Do you have, or have you had any significant emotional problems? **Yes No**
- Have you ever had psychiatric care? **YesNo**
- Have you ever been advised to see a Psychiatrist? **Yes No**
- Have you ever had Herpes? **Yes No**

Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_