Plastic Surgery Institute of New Mexico

# Patient Information

*Neil T. Chen, MD, Medical Director*
*Christopher D. Knotts, MD, FACS*

*Last Name:_____First Name:_____Mid. Init._*

*Date of Birth_____Age_____Occupation_____*

*Referral by ( ) friend/family _____ ; ( ) web research; ( ) doctor _____; ( ) magazine; ( ) other _____*

*Address:_____*

*City_____State_____Zip_____*

*Phone (home)_____; (work)_____; (mobile)_____ Circle the best contact number*

*Preference of appointment reminder: __ email, or __ text messaging: cell phone carrier: _____*

*e-mail_____ May we email you reminder/ communication? Y / N*

*Person to contact in an emergency_____Phone_____Relation_____*

*Family physician _____ When was your last physical exam? _____*

*Topic for consultation today:_____*

**Acknowledgement of Receipt of HIPPA Policy**

I hereby acknowledge that I have read and have the opportunity to receive a copy of this practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.
Enter email address if you would like to receive a copy of amended Notice of Privacy by e-mail:
If not signed by patient, indicate relationship: __ parent or guardian of minor patient, __ guardian or conservator of an incompetent patient

*By signing below:*

*I verify that the information I provide is complete, true, and correct to the best of my knowledge*
*I agree to comply fully with my care, instruction, treatment and medication prescribed to me*
*I authorize the release of medical information to and from Dr. Chen deemed medically necessary for my treatment.*
*I agree to be responsible for all financial charges incurred as a result of my evaluation and treatment. Outstanding balance after 60 days is subject to monthly finance charge of 1.5% per month. I understand that the cost of collection in case of delinquency (90 days past due) will be added to my account.*
*I acknowledge that there is a non-refundable and non-transferable scheduling fee when you book a surgical procedure. There is possible cancellation fee as described in the "Quote" document which you will receive.*
*I waive my privacy right under HIPPA for the verification of service provided to the third party payer if financial disputes arise.*
*I further acknowledge all refunds for funds paid with credit cards are subject to deduction of processing fees of 2.5%.*
*I agree that a copy of this document bearing my signature has the same effect as the original*

***Patient signature_____Date_____***

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Do not write below – Office use only – version 04.09.2017

# SANDIA SURGERY CENTER PRE-OP QUESTIONNAIRE

Todays Date ___ /___ /___

Name: _____ Age:_____ Date of Birth ___ /___ /___ Height _____ Weight _____ lbs

Contact Phone - Home/Cell: _____ Work: _____ Occupation:_____

**Medications** (including supplements, herbal and over the counter) _____

_____

_____

_____

**Allergies:** NONE Penicillin Keßex Sulfa Bactrim Septra Erythromycin Iodine Latex Other:_____

_____

**Prior Surgeries** / Hospitalizations _____

_____

_____

For Women Only: Pregnancies #:_____ Children # _____. Last Mammogram Date: ___ / ___ / ___ Results_____

| ANY MEDICAL HISTORY OF | NO | YES | IF "YES" CHOSEN, CIRCLE or FILL IN APPROPRIATE ANSWER/CONDITION |
|---|---|---|---|
| Any **LUNG** problems ? | ☐ | ☐ | Asthma COPD Emphysema Pneumonia Cystic Fibrosis Home O2 Use<br>Shortness of Breath Pulmonary Embolus Other diagnosis _____<br>Steroid use for Asthma (yes) (no) Emergency room visits for Asthma ? (Yes) (No) |
| Prior or current **SMOKING** or Vaping ? | ☐ | ☐ | Current Cigarettes Packs per day _____ Vaping (number of years)_____<br>Quit for _____ weeks/months/years |
| **SLEEP APNEA** ? | ☐ | ☐ | Years of diagnosis _____ Do you use CPAP? (YES) (NO) |
| **HYPERTENSION** (High blood pressure) ? | ☐ | ☐ | Years of diagnosis _____ Treated ? (YES) (NO) _____ |
| **HEART** problems ? | ☐ | ☐ | Have you even seen a Cardiologist ? (YES) (NO) when?_____<br>Heart Valve_____ Arrhythmia._____ Chest pain_____ Angina_____ Stents_____ Heart Attack (MI) _____ Heart Failure_____<br>Pacemaker _____ AICD_____ Other:_____ |
| **STOMACH** or GI problems ? | ☐ | ☐ | Hiatal Hernia GERD (Reßux) Stomach Ulcers Liver Cirrhosis<br>Intestinal or other problems _____ |
| **KIDNEY** problems ? | ☐ | ☐ | Kidney stones Infection Renal Failure Type _____ Dialysis<br>Are you currently under the care of a nephrologist (YES) (NO) |
| **DIABETES** ? | ☐ | ☐ | Type 1 (Insulin dependent). Type 2 Pre-diabetes Years since diagnosis _____ |
| **THYROID** problems ? | ☐ | ☐ | (Circle one). HYPERthyroid HYPOthyroid Number of years _____.<br>Other _____ |
| **NEUROLOGIC** problems ? | ☐ | ☐ | Headache. Migraine ADHD Seizures (frequency/duration)_____<br>TIA Stroke (when and deP cit) _____ Cerebral Palsy Parkinson's Dementia<br>Alzheimer's other_____ |
| **ORTHOPEDIC** or **JOINT** Problems ? | ☐ | ☐ | Fractures (old) (new) where ?_____ Arthritis: Degenerative. Rheumatoid Osteoarthritis<br>Neck problems TMJ Years _____ Joints affected _____ |
| **CHRONIC PAIN** ? | ☐ | ☐ | Location of Pain _____ number of years _____.<br>Do you take (NSAIDS) (Tylenol). (Narcotics) (Suboxone). Other therapy _____ |
| Chronic or new **INFECTIONS** ? | ☐ | ☐ | Herpes_____ Tuberculosis_____ Hepatitis A, B or C_____ HIV/AIDS_____ Other _____<br>Is infection active? (yes)☐ (no)☐ |
| **BLEEDING** or **BLOOD** problems ? | ☐ | ☐ | Anemia _____ Hemophilia (type)_____ Factor Defciency (type)_____ Transfusion History (yes)☐ (no)☐<br>Sickle Cell _____ Leukemia _____ Blood Clots _____ Other _____ |
| ALCOHOL consumption ? | ☐ | ☐ | Frequency #_____ (drinks) per _____ Quit Alcohol _____ |
| Any use of **CANNABIS** or "Street" Drugs ? | ☐ | ☐ | Cannabis _____ Cocaine _____ Methamphetamines _____ Hallucinogens_____ Narcotics_____<br>Describe amount/frequency_____ Last time taken _____ |
| **CANCER** ? | ☐ | ☐ | Type of cancer _____ year diagnosed _____<br>treatment: (Chemo) ____ (Radiation)____ (Surgery) ____ Status of treatment _____ |
| Previous **ANESTHESIA i**ssues with you or family member ? | ☐ | ☐ | Please Describe : _____ |
| Females only : Any chance of **PREGNANCY** ? | ☐ | ☐ | Date of Last Menstrual Period _____.<br>If answer "no", Why ?_____ |
| ANY OTHER MEDICAL ISSUE NOT COVERED | ☐ | ☐ | Please Describe any other medical issue |

I verify that the information provided is complete, true and correct to the best of my knowledge. I authorize the release of this medical information to the Sandia Plastic Surgery staff, surgeons, anesthesia and facility providers.

Patient Signature. _____. Date ___ / ____ / ____