CMC Cosmetic and Plastic Surgery

1025 Morehead Medical Drive, Suite 200 • Charlotte, NC 28204
Phone (704) 446-6810 • Fax (704) 446-6835

Name: ______________________________ Date: ______________

Primary Care Physician: ______________ Referring Physician: ______________

Reason for visit: ______________________________

Physician ONLY:

(HPI: Location, Duration, Timing, Severity, Quality, Modifying Factors, Associated Signs and Symptoms, Context)

Current Medications (Including Over the Counter Meds and Herbals):

______________ ______________
______________ ______________
______________ ______________
______________ ______________

ALLERGIES: ______________________________

Past Medical Illnesses / Hospitalizations (Non-Surgical) and Approximate Dates:

______________ ______________
______________ ______________
______________ ______________
______________ ______________

Previous Surgeries and Approximate Dates:

______________ ______________
______________ ______________
______________ ______________

Have you ever had any of the following?

Stroke	☐No	☐Yes	HIV+ or AIDS	☐No	☐Yes	Bleeding Tendency	☐No	☐Yes
Heart Disease	☐No	☐Yes	Glaucoma	☐No	☐Yes	Thyroid Disease	☐No	☐Yes
Stomach Ulcers	☐No	☐Yes	Cancer	☐No	☐Yes	Rheumatic Fever	☐No	☐Yes
Hepatitis	☐No	☐Yes	Asthma	☐No	☐Yes	High Blood Pressure	☐No	☐Yes
Arthritis	☐No	☐Yes	Sleep Apnea	☐No	☐Yes	Tuberculosis	☐No	☐Yes
Anemia	☐No	☐Yes	Blood Clots	☐No	☐Yes	Diabetes	☐No	☐Yes

Atrium Health

870

Patient Information or Sticker

Name:

DOB:

Medical Record #:

Family History:

Please place a check mark if any blood relative has had any of the following:

- ☐ Breast Cancer
- ☐ High Blood Pressure
- ☐ Hemophilia
- ☐ No Known Conditions
- ☐ Problems with Anesthesia ______________________________
- ☐ Melanoma
- ☐ Ovarian Cancer
- ☐ Blood Clots
- ☐ Other ______________________________
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Colon Cancer

Social History:

Do you currently smoke? ☐No ☐Yes If yes, amount per day ____________
Are you a former smoker? ☐No ☐Yes If yes, when did you quit? ____________
Do you drink alcohol? ☐No ☐Yes If yes, amount per week ____________
Occupation: ______________________
Marital Status: ☐M ☐D ☐S ☐W
Number of Children: __________
Do you plan on having more children? ☐No ☐Yes

Review of Systems:

Please check YES or NO if you have had any of the following symptoms in the past year:

Symptom	No	Yes
Weight Changes	☐No	☐Yes
Chest Pain	☐No	☐Yes
Jaundice	☐No	☐Yes
Seizures	☐No	☐Yes
Joint Pain	☐No	☐Yes
Chronic Cough	☐No	☐Yes
Easy Bruising	☐No	☐Yes
Fever Blisters	☐No	☐Yes
Swollen feet/ankles	☐No	☐Yes
Problems swallowing	☐No	☐Yes
Nausea/Vomiting	☐No	☐Yes
Rapid Heart Beat	☐No	☐Yes
Depression	☐No	☐Yes
Easy Bleeding	☐No	☐Yes
Muscle Pain	☐No	☐Yes
Shortness of Breath	☐No	☐Yes
Trouble urinating	☐No	☐Yes
Dry Eyes	☐No	☐Yes
Fever/Chills	☐No	☐Yes

Women Only:

Have you ever had a mammogram? ☐No ☐Yes If yes, when? ____________
Do you do regular self breast exams? ☐No ☐Yes
Have you ever had breast lumps or discharge ☐No ☐Yes
Did you breast feed? ☐No ☐Yes
Bra Size __________
Have you had a C-Section ☐No ☐Yes

Signature: ______________________________ **Date:** ____________

Relationship to Patient: ______________________________

Physician's Signature: ______________________________ **Date:** __________ **Time:** ________

Patient Information or Sticker

Name:

DOB:

Medical Record #: