

PLASTIC AND RECONSTRUCTIVE SURGERY, P.C.

Michael W. Born, M.D., F.A.C.S.
Certified: American Board of Surgery
American Board of Plastic Surgery

2295 S. George St., York, PA 17403 T: 717 741-9599 F: 717 741-0420 Toll Free 877 741-9599 www.plasticsurgery.org/md/michaelwbornmd.htm

Patient Information

First Name _____ M.I. ____ Last Name _____

Address _____ City _____ St _____ Zip _____

Date of Birth _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Pharmacy Name _____ Phone _____ Address _____

Physician Information

Referring Physician _____ Phone Number _____

Family Physician _____ Phone Number _____

OB/GYN Physician _____ Phone Number _____

Insurance Information

Primary Insurance _____ Employer _____

Identification Number _____ Group Number _____

Policy Holder (if other than self) _____ Date of Birth _____

Relationship to patient _____

Secondary Insurance _____ Employer _____

Identification Number _____ Group Number _____

Policy Holder _____ Date of Birth _____ Relationship to patient _____

Workers Comp or Auto Insurance

Date of Injury _____ Claim Number _____

Employer (if workers comp) _____ Phone _____

Insurance Name _____ Phone _____

Address _____

Adjustor Name _____ Fax _____

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Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

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HIPAA PRIVACY INFORMATION
(check yes/no to the following questions)

PATIENT NAME _____

May we leave **APPOINTMENT** information:

Home Phone	_____ **YES**	_____ **NO**
Cell Phone	_____ **YES**	_____ **NO**
Office Voice Mail	_____ **YES**	_____ **NO**
Another Person	_____ **YES**	_____ **NO**
Send Via Mail	_____ **YES**	_____ **NO**
Patient Portal	_____ **YES**	_____ **NO**

May we leave **MEDICAL** information:

Home Phone	_____ **YES**	_____ **NO**
Cell Phone	_____ **YES**	_____ **NO**
Office Voice Mail	_____ **YES**	_____ **NO**
Another Person	_____ **YES**	_____ **NO**
Send Via Mail	_____ **YES**	_____ **NO**
Patient Portal	_____ **YES**	_____ **NO**

If you want another person(s) to access your appointment/medical information, please list the names(s) and relationship below.

Contact	Relationship (family/friend)	Phone Number

Patient requested Notice of Privacy Practices **YES** **NO** **Initial** _____

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Plastic and Reconstructive Surgery, P.C.
Michael W. Born, M.D., F.A.C.S. Appt Date: _____

Patient Health History Questionnaire Date: _____

Name: _____ DOB: _____ Age: _____ Gender: M F

How did you hear about Dr. Born and the practice?
Doctor / Family / Friend / Co-Worker / other: _____

REASON FOR YOUR CONSULTATION: (include symptoms and location on body)

_____

When did symptoms occur? Month/Day/Year _____
Have you ever had same or similar condition? Yes No If yes, When? _____
IF AN INJURY OR ACCIDENT: Date/Time/Location (home, work, car, etc.)? _____
Describe incident: _____

Name of person(s) in the room with patient today: _____ Relationship to patient: _____
(Person must be on HIPAA release form)

LIST ALL DRUG AND NON-DRUG ALLERGIES / SEVERITY / REACTION
(mild, mild to moderate, moderate, moderate to severe, severe, fatal) Ex: Penicillin- severe- rash

☐ NO KNOWN DRUG ALLERGIES ☐ LIST OF ALLERGIES INCLUDED

_____
_____
_____
_____

LIST OF ALL MEDICATIONS-
(current and as needed medications)

INCLUDE DOSAGE, HOW OFTEN, AND WHY
Ex: Lisinopril 5mg once daily blood pressure

☐ NO MEDICATIONS ☐ LIST OF MEDICATIONS INCLUDED

_____
_____
_____
_____
_____

Do you have a medical marijuana card? ☐ No ☐ Yes Type: _____
Do you take any blood thinners? ☐ No ☐ Yes _____
Over the counter medications: _____
Vitamins and/or herbal supplements: (i.e. CBD, oils, etc.) _____

Influenza (flu) Vaccine	☐ No	☐ Yes	☐ Does not receive	Date: _____
COVID-19 Vaccine	☐ No	☐ Yes	1st dose date: _____	2nd dose date: _____
Pneumococcal Vaccine	☐ No	☐ Yes	☐ Does not receive	Date: _____
Tetanus Vaccine	☐ No	☐ Yes	☐ Within 10 years	Date: _____
Living Will	☐ No	☐ Yes		
Mammogram	☐ No	☐ Yes	Results: _____ Date: _____	Facility: _____
HgA1c (if diabetic)	☐ No	☐ Yes	Results: _____	Date: _____

MEDICAL HISTORY (6 months or longer)

Have you ever had any of the following?

	Yes	No		Yes	No
Abdominal aortic aneurysm	☐	☐	Heartburn/ Reflux/ GERD	☐	☐
Alzheimer's disease	☐	☐	Hepatitis/ Liver disease	☐	☐
Anemia	☐	☐	High blood pressure	☐	☐
Anxiety	☐	☐	High cholesterol	☐	☐
Arthritis	☐	☐	HIV/AIDS	☐	☐
Asthma	☐	☐	Kidney disease	☐	☐
Back disorder	☐	☐	Lung disease	☐	☐
Bleeding disorder	☐	☐	Malignant hyperthermia	☐	☐
Blood clots/DVT	☐	☐	Melanoma	☐	☐
Cancer (location)	☐	☐	Migraines	☐	☐
Carotid artery disease	☐	☐	MRSA/Serious infection	☐	☐
Crohn's/Irritable bowel	☐	☐	Neuropathy	☐	☐
COPD	☐	☐	Osteoporosis	☐	☐
Congestive heart failure/CHF	☐	☐	Pacemaker/defibrillator	☐	☐
Coronary artery disease	☐	☐	Problems with Anesthesia	☐	☐
Diabetes- Type I	☐	☐	Prostate problems	☐	☐
Diabetes- Type II	☐	☐	Psychiatric disease	☐	☐
Depression	☐	☐	Pulmonary embolus	☐	☐
Emphysema	☐	☐	Rheumatoid arthritis	☐	☐
Epilepsy/Seizures	☐	☐	Sleep Apnea	☐	☐
Gallbladder disease	☐	☐	Stroke	☐	☐
Glaucoma	☐	☐	Thyroid disease	☐	☐
Gout	☐	☐	Vascular disease/stents	☐	☐
Heart attack/MI	☐	☐	Venereal disease/STD	☐	☐
Heart murmur	☐	☐	Ulcers (type of ulcers)	☐	☐

Other: _____

Assistive Devices: (circle all that apply)

None Glasses Reading Glasses Contacts Cane Crutches CPAP

Oxygen Walker Wheelchair Dentures (complete / partial / upper / lower)

Hearing Aid (left / right / both) Glucose Monitor Implanted Neurostimulator

Other: _____

LIST SURGERIES (include side of body) AND/OR HOSPITAL ADMISSIONS (include childbirth)

☐ NONE ☐ LIST OF SURGERIES INCLUDED

	Month/Year	Hospital

FAMILY HISTORY

☐ **Unknown family history** ☐ **Adopted**

Circle if parents are LIVING or DECEASED (if deceased, list reason)

DISEASE	Age: FATHER- LIVING DECEASED	Age: MOTHER- LIVING DECEASED
High blood pressure/hypertension		
Heart attack/ MI		
Diabetes (type I or type II)		
Gout		
Cancer (type)		
Skin Cancer		
Melanoma		
DVT/ Clots in legs		
Pulmonary Embolism/ Clot in lung		
Describe problems with anesthesia		
Bleeding disorder		
Stroke		
Thyroid problems		
Other		

Family history of breast cancer (list family members and if MATERNAL and/or PATERNAL)

_____

Family history of malignant Hyperthermia (list family members and if MATERNAL and/or PATERNAL)
(Definition: rare life-threatening condition that is usually triggered by exposure to certain drugs used for general anesthesia. The drugs can overwhelm the body's capacity to supply oxygen, remove carbon dioxide and regulate body temperature, eventually leading to circulatory collapse and death if not immediately treated.)

_____

SOCIAL HISTORY (complete every area)

Hand dominance: ☐ Right Hand ☐ Left Hand ☐ Ambidextrous

Marital Status: Divorced Domestic Partner Legally Separated Married Never Married Widowed

Occupation: _____ Employer: _____
If currently in: School/College: _____ Grade: _____

Retired: Yes No Disabled: Yes No

YOUR PERSONAL HABITS:
Do you use or have ever used Nicotine? Yes No Amount _____ Number of years _____
What form(s) of nicotine? _____
When did you quit? _____ How did you quit? _____

Caffeine use: Coffee Tea Soda Energy Drinks other: _____ Amount: _____ per day
Do you drink alcohol? Yes No Amount and type(s): _____
History of Drug and/or Alcohol abuse? Yes No Type(s): _____
Do you have a narcotic contract agreement? Yes No Provider/Prescription: _____

Have you been out of the country within the past year? Yes No If yes, Where: _____

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Name: _____ Date: _____

REVIEW OF SYSTEMS (CIRCLE ALL THAT APPLY)

GENERAL: fatigue / fever / sweats

EYES: blurred vision / change in vision / double vision

EARS, NOSE, MOUTH, THROAT: hearing loss / ear pain / allergies / bloody nose / congestion
Sore throat

CARDIOVASCULAR: chest pain / pressure / irregular heartbeat / swelling of ankles

RESPIRATORY: cough / sneezing / shortness of breath / wheezing

GASTROINTESTINAL: constipation / diarrhea / nausea / bloody stools / vomiting

GENITOURINARY: difficulty voiding / frequency / blood in urine / burning with urine

MUSCULOSKELETAL: joint pain / muscle pain / joint swelling
location and side(s) of body:

SKIN: hives / itchy skin / poor healing / rash / lesion /laceration

BREAST: breast problems: (list)

NEUROLOGIC: headache / numbness / tingling / weakness

PSYCHIATRIC: anxiety / depression / insomnia / memory loss
suicidal thoughts

ENDOCRINE: change in appetite / excessive fatigue / intolerance to cold
intolerance to heat / excessive thirst / excessive urination
weight gain / weight loss

HEMATOLOGIC / LYMPHATIC: easy bleeding / excessive bleeding / easy bruising

PATIENT HERE WITH:

Self	Spouse
Mother / Father	Grandparent _____
Significant other	Children _____
Friend	Other _____

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____
Patient's Signature (parent / guardian for minor) Date Print Name

OFFICE USE ONLY:

BP _____ left right PULSE _____ TEMP _____ HT _____ WT _____