

Renaissance Plastic and Reconstructive Surgery, P.A.
History Intake Form
(Please respond to each section on this form)

Patient Full Name: _____ **DOB:** _____

Reason for visit: _____ **Date of visit:** _____

Medications: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

Medication	Dose	Times / day		Medication	Dose	Times / Day

Allergies or Reactions to medicines / foods / other agents:

Medication	Reaction or side effect

Past Medical History: _____

Surgical History: _____

Family History of Disease: _____

Breast Cancer in Family: _____

Social History:

Do you use any recreational drugs? _____

Do you use tobacco? (Type & Amount per week) _____

Do you drink alcohol? (Type & Amount per week) _____

Height: _____ Weight: _____

Bra size: _____

Number of pregnancies: _____ Date of last pregnancy: _____

Are you pregnant? _____ Date of last mammogram: _____

Regular breast self examinations? _____ Breast lump or discharge? _____

Primary Care MD Name: _____

Referring MD Name: _____