



Paul H. Rhee, M.D.
6642 E. Baseline Rd., Suite #103
Mesa, AZ 85206
(480)641-7720 Phone
(480)641-3112 Fax

PATIENT HEALTH INFORMATION

NAME: _____ Today's Date: _____

Last, First, MI

Address: _____ City, State: _____ Zip: _____

Home Phone # (____) _____ Cell Phone # (____) _____

Work # (____) _____

Email Address _____

Date of birth: _____ Age: _____ SEX: Male / Female

Social Security # _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Notify in case of emergency:

Name: _____ Relationship _____ Phone #: _____

Name of Employer: _____

Address: _____ City: _____ Zip: _____

Occupation: _____

Primary Care Physician: _____ Phone number: _____

Street address: _____

City: _____ State: _____ Zip: _____

Who can we thank for referring you to our office? _____

Referring Physician: _____ Phone number: _____

Street address: _____

City: _____ State: _____ Zip: _____

Health Insurance Information (if applicable)

Insurance Company: _____

Address: _____

Phone number: _____ Policy Holders Name _____

ID# _____ Group # _____

I. GENERAL

a. Specific reason(s) for which you are being seen (circle all that apply):

Aesthetic Surgery **Reconstructive Surgery**

Face, Small Breasts, Breast Reconstruction

Neck, Large Breasts, Skin Cancer/Lesion

Brow, Sagging Breasts, Facial/Nasal/Ear Injury

Eyes, Excess Truncal Skin, Scars

Nose, Abdomen, Burn Injury

Lips, Lower Extremity, Wound Care

Ears, Buttocks, Wrinkles ER Follow-up

Liposuction

Other _____

Patient Initials _____

b. Have you seen other doctors for this reason? **Yes No**

If so, who? _____

c. Have you been previously treated for this problem? **Yes No**

d. If so, please indicate:

Year/Treatment/Procedure/Physician/Complications

II. PAST MEDICAL HISTORY

a. What is your present: Height: _____ Weight: _____

b. Please indicate if you **HAVE** or **have HAD** any of the following medical problems:

Eye Problems (eg. Dry eyes/Glaucoma/Tearing)

Nasal Problems (eg. Bleeding/Sinusitis/Difficulty breathing/Runny nose)

Neurological/Emotional Problems (eg. Headaches/Seizures/Depression)

High Blood Pressure

Heart or Circulatory problems (eg. Chest pain/Heart Attack/ High cholesterol)

Respiratory problems (eg. Asthma/Pneumonia/Shortness of breath)

Gastrointestinal Problems (eg. Ulcer/Hernia/Reflux)

Genitourinary Problems (eg. Voiding problems/

Menstrual problems/Impotence/Kidney stones)

Endocrine/Immune Problems (eg. Thyroid problems/Diabetes/HIV/AIDS/Lupus)

Bleeding Problems (eg. Easy bruising/Clots/ Anemia)

Musculoskeletal Problems (eg. Arthritis/Weakness/

Fibromyalgia/Limited mobility/Numbness/Tingling)

Cancer (please indicate type) _____

c. Please list any additional medical issues and any non-surgical hospitalizations or emergency room visits requiring treatment. (Please list additional problems on the last page.)

Year/Problem/Treating Physician

III. PAST SURGICAL HISTORY

a. Have you ever had surgery, including *Plastic Surgery*? **Yes No**

b. If you have had Plastic Surgery, please rate your results:

Excellent Good Fair Poor

c. If your results were fair or poor, please describe briefly.

d. Please list all prior surgical procedures. (This includes removal of tonsils/appendix/gallbladder, LASIK surgery, wisdom tooth extraction, etc.) List additional surgeries on the last page.

Year/Procedure/Surgeon/Complications

e. If you have had surgery, check type(s) of anesthesia you received and circle any problem(s).

General Anesthesia: Nausea/Vomiting/Slow awakening/Difficult Intubation/Other _____

IV Sedation: Nausea/Vomiting/Slow awakening/Other _____

Epidural/Spinal: Nausea/Vomiting/Insufficient/Bleeding/Headache/Other _____

Patient Initials _____

Block: Insufficient /Prolonged/Systemic reaction Other _____
(eg. Axillary, regional, etc.)

Local: Insufficient block/Heart palpitations/Systemic reaction/Other _____

IV. MEDICATIONS

a. Do you require antibiotics prior to surgery? **Yes No**

If so, why? _____

b. Do you take any medications including vitamins? **Yes No**

c. If so, please indicate. Name Dose

Blood pressure pills _____

Water pills _____

Blood thinners _____

Steroids _____

Insulin _____

Hormone replacement therapy _____

Vitamins (eg. B, C, E, K, etc.) _____

d. Please list **ALL** additional medications that you take. List additional medications on the last page.
Medication/Dose/Why?

e. Do you take any herbs, dietary supplements, or weight reduction products? **Yes No**

If so, please circle.

Echinacea, Ephedra, (*Ma Huang*), Feverfew, Garlic, Gingko,

Ginseng, Goldenseal, Kava-Kava, Licorice, METABO-life,

St. John's Wort, Saw Palmetto, Valerian

Others _____

f. Do you take aspirin or ibuprofen products? **Yes No**

If so, please indicate.

Aspirin (ASA/Bayer/Ecotrin/Excedrin/Fiorinal/etc)

Ibuprofen (eg. Advil/Motrin/etc)

Non-steroidal anti-inflammatories (eg. Aleve/Anapro/Daypro/Toradol/etc)

Others _____

V. ALLERGIES & SENSITIVITIES

a. Medication Allergies or Sensitivities? **Yes No**

If so, please indicate drug and circle reaction(s).

Penicillin: Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other _____

Sulfa: Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other _____

Morphine: Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other _____

Codeine: Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other _____

Other Medication(s) / Reaction

_____ Rash/Hives/Anaphylaxis/Swelling/Nausea/Vomiting/Other _____

_____ Rash/Hives/Anaphylaxis/Swelling/Nausea/Vomiting/Other _____

b. Environmental or Food Allergies? **Yes No**

c. Latex Allergies? **Yes No**

d. Tape or Adhesive Sensitivities? **Yes No**

If so, please list type of tape or adhesive _____

VI. SOCIAL HISTORY

a. Children (birth years): _____

b. Do you smoke? **Yes No** / Have you ever smoked? **Yes No**

If yes, please indicate and circle appropriate reply:

_____ Cigarettes or Packs/Day, for _____ Years or Quit _____ Weeks/Months/Years ago

c. Do you drink alcohol? _____ Times/Day _____ Times/Week _____ Rarely _____ Never

d. Do you drink caffeinated beverages? **Yes No** If yes: _____/Day

e. Do you use any recreational drugs? **Yes No**

If yes, please indicate: _____

Patient Initials _____

VII. FAMILY HISTORY

Please indicate the Problem and the Relationship

Do you have a family history of:

Heart problems **Yes No** _____

Diabetes **Yes No** _____

Breast cancer **Yes No** _____

Other cancers **Yes No** _____

Bleeding problems **Yes No** _____

Anesthesia problems **Yes No** _____

Other problems **Yes No** _____

VIII. ADDITIONAL INFORMATION

SIGNATURE: _____

My signature above certifies that I have completely and accurately filled out the information on this form. I understand that inaccuracies in this information may be detrimental to my care and potentially result in severe medical consequences.

Patient Initials _____