INITIAL CONSULTATION

Michael Bublik, M.D.
Facial Plastic Surgery/ Ear, Nose, and Throat / Allergy

Today's Date ____/____/_____ Age _____
First Name _____ Birth Date ____/____/_____
Last Name _____ ❑ male ❑ female
Email_____
How did you hear about us:_____
Are you interested in any cosmetic procedures? ❑ yes ❑ no

Primary Care Physician (PCP)
Name _____
Address _____
_____
Phone # _____
Fax # _____

Physician Requesting Consult
❑ - same as PCP
Name _____
Address _____
_____
Phone # _____
Fax # _____

Main reason for the visit: _____

Describe this problem (location, duration, severity, timing, etc) _____
_____
_____
_____

What makes your symptoms feel better? _____
feel worse? _____

Prior treatments (medications / procedures) **for this complaint**:

_____ _____
_____ _____
_____ _____

Review of Systems: Check all that apply

❑ Fatigue	❑ Chest tightness	❑ Painful urination	❑ Numbness
❑ Fever	❑ Wheezing	❑ Blood in the urine	❑ Seizures
❑ Nose bleeds	❑ Chest pain	❑ Walking problem	❑ Easily bleed/bruise
❑ Dental problems	❑ Leg swelling	❑ Joint swelling	❑ Behavior problem
❑ Light sensitive	❑ Stomach pain	❑ Skin color change	❑ Hallucinations
❑ Vision problems	❑ Blood in stool	❑ Extreme paleness	

M___ T___ *OFFICE USE ONLY:*
L - R - B Sept NP F/U Cnslt FNA/ Bx
mld-mod-sv Turb NC- NP- LX
ap - lat Muller
ap - lat BOT PRN ____wk-mo OR CT p___

[patient sticker/imprint]

MEDICAL HISTORY: Check all that apply to you

- ❑ High cholesterol
- ❑ High blood pressure
- ❑ Diabetes
- ❑ Migraines
- ❑ Thyroid disorder
- ❑ Heart disease
- ❑ Arrhythmias
- ❑ Heart attack
- ❑ Mitral valve prolapse
- ❑ Bleeding disorder
- ❑ Kidney disease
- ❑ Facial trauma / fractures
- ❑ Head injury
- ❑ Stroke
- ❑ TIA ("mini-stroke")
- ❑ Psychiatric treatment
- ❑ Asthma
- ❑ COPD (bronchitis/emphysema)
- ❑ HIV positive
- ❑ STD – syphilis, gonorrhea
- ❑ Anemia
- ❑ Hiatal hernia
- ❑ Significant arthritis
- ❑ DVT (blood clot in vein)
- ❑ Hepatitis
- ❑ Autoimmune disease: _____
- ❑ Organ transplant:_____
- ❑ Cancer: _____
- ❑ Tumor, growth, cyst: _____
- ❑ Other medical problems: _____ _____

SURGICAL HISTORY: List ALL surgeries (include plastic surgery, tonsillectomy, etc)

Year	Procedure	Year	Procedure
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY:

Current **tobacco** use: ❑ Yes ❑ No
_____ # packs per day
for _____ years
Prior tobacco use: ❑ Yes ❑ No
When did you quit? _____

Current **alcohol** use: ____ drinks per day
____ drinks per week

Current **caffeine** use:
Coffee, Tea, or Soda = ____ cups per day

Have you ever used "**recreational drugs**"
(marijuana, cocaine, etc)? ❑ Yes ❑ No
If yes, please list: _____

FAMILY MEDICAL HISTORY: Check all that apply to your blood relatives

- ❑ Cancer
- ❑ Heart disease
- ❑ Stroke
- ❑ Allergies
- ❑ Asthma
- ❑ Diabetes
- ❑ High blood pressure
- ❑ Autoimmune disease
- ❑ Bleeding disorder (i.e. hemophilia)

ALLERGIES TO MEDICATIONS: ❑ No allergy
❑ I am allergic to: _____

MEDICATIONS: List **current** prescription and over-the counter medications: ❑ None

_____	_____	_____
_____	_____	_____
_____	_____	_____

The information supplied reflects an accurate description of my medical history to the best of my knowledge.

Patient Signature _____ Date _____