Bengtson Center
for AESTHETICS & PLASTIC SURGERY

Patient Information:

Name			
First	Middle Initial	Last	Maiden Name
Date of Birth:	What is your height?	Current weight?	Previous weight?
Phone# ( )	Current Physician's name and phone number		

Please list current medications including vitamins, over the counter and herbal meds, homeopathic supplements, respiratory or diet pills

	Dosage and Frequency
1)	
2)	
3)	
4)	
5)	
6)	
7)	

Allergies: Please list any medications that have caused allergic reactions, including latex

Do you have or have had any of the following?	Yes	No
Heart disease		
Lung Disease		
Stroke, mini-stroke		
Bronchitis		
Cancer		
Depression		
Diabetes, Blood sugar issues		
Dizziness/Vertigo		
Ear Infections		
Epilepsy/Seizures		
Facial Pain		
Fever Blisters		
Thyroid Disease		
Hay Fever/Seasonal Allergies		
Headaches		
Heart Trouble/Murmur		
Hepatitis/Liver		
High Blood Pressure		
High Cholesterol		
Kidney Problems		
Pneumonia		
Sinus Problems/Infection		
Asthma		
Tonsillitis		
Tuberculosis		
Ulcers		
Arthritis		
Aids/HIV		
Other		

Please See Other Side

Over the last 6 months have you experienced any of the following:	Yes	No	If yes, please explain
Weight loss, fevers, chills			
Blurry vision, eye pain			
Sore throat, ear pain, nose bleeds			
Chest pain, palpitations, swelling in legs/feet			
Anxiety, depression, alcohol/drug dependence			
Increased thirst, excessive sweating			
Tremors, numbness, slurred speech			
Joint pain, muscle aches, frequent leg cramps			
Painful or frequent urination, blood in urine			
Shortness of breath, chronic cough			
Trouble awakening, difficulty staying asleep, dozing off during the day			

Social/Personal History:	Explanation:
Do you smoke or use tobacco or nicotine products?	
Do you drink alcohol?	
If yes, how much do you drink alcoholic beverages?	
Do you use recreational drugs?	
Do you have bleeding or bruising problems? Clotting?	
Do you have problems with scarring?	
Do you have any history of problems with anesthesia?	

List Prior Surgeries	Date of occurrence:

List any serious illnesses and or accidents	Date of occurrence:

Gender Specific		
Females Only: Number of children		
Females Only: Number of pregnancies		
Females Only: Last mammogram, if any		Results?
Males Only: Have you had prostate disease?		

Family History	Please list any known medical problems
Father:	
Mother:	
Siblings:	
Your Children:	

Emergency Contact: _____ **Phone #** _____

Pharmacy Preference: **If needed, is there a specific pharmacy you would like us to call in prescriptions to?**

_____

I attest that the personal information I have given is true and accurate to the best of my knowledge.
I hereby authorize Bengtson Center and its providers to proceed with my medical treatment.
I understand that I am responsible for any charges incurred at Bengtson Center.
I hereby acknowledge that I have been offered to receive a copy of Bengtson Center Notice of Privacy Practices.
I would like a written copy of Bengtson Center privacy policy ☐Yes ☐No

_____ _____

Printed Name of Patient/Legal Guardian Signature of Patient/Legal Guardian Date