James S. Kadi, M.D.

Cosmetic & Reconstructive Surgery

Diplomate of the American Board of Plastic Surgeons

Patient Information

Name _____Date of Birth _____ Age_____ Sex: male female

Home Phone_____Business Phone _____

Cell Phone _____ E-Mail Address _____

SS# _____ Marital status: married single Pharmacy _____

Home Address _____
Street City State Zip

In case of Emergency contact: Name _____ Phone _____

Person responsible for payment of account_____

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

Who is your family physician?_____

What is the reason you are consulting Dr. Kadi?_____

Employer_____

Address_____

City_____

State_____ Zip_____

Employee Type:

Retired
Employed Full Time
Employed Part Time
Not Employed
Student

Primary Insurance Information

Plan Name_____

Address _____

City _____

State_____ Zip_____

Policy #_____

Group #_____

Policy Holder_____

Relationship _____Date of Birth_____

Employer_____

Address_____

City_____

State_____Zip_____

Secondary Insurance Information

Plan Name_____ Policy Holder_____

Address _____ Relationship _____Date of Birth_____

City _____ Employer_____

State_____ Zip_____ Address_____

Policy #_____ City_____

Group #_____ State_____Zip_____

MEDICAL HISTORY

1. Do you consider yourself to be in good health? YES NO

2. Have you seen a physician for a medical problem within the past year**?** This includes Emergency room and any surgeries you have had. YES NO. **If YES, for what reason?**

_____

_____

_____

3. Are you allergic to any drugs/medications? YES NO **If YES, please list.**

_____

_____

4. Are you taking any medication or drugs now? YES NO **If YES, please list with dosages and amounts**.

_____

_____

_____

_____

5. Have you had surgery before (include cosmetic surgery)?**.** YES NO **If YES, please list procedure and approximate date.**

_____

_____

_____

_____

6. Do you take aspirin on a daily basis? YES NO

7. Have you ever had an unusual reaction to a local or general anesthetic? YES NO

8. Have you ever had radiation treatment? (For example, for cancer, skin rashes, etc.) YES NO

9. **Family History:** Has any immediate relative (father, mother, brother, sister) ever had any of the following?

High blood pressure……. no yes	Breast cancer……. no yes	Kidney disease……. no yes
Heart disease…… no yes	Melanoma……..… no yes	Depression……. no yes
Diabetes……. no yes	Stroke…….. no yes	

10. **Past Medical History:** Do you have a history of problems with any of the following? **If so, PLEASE CIRCLE**.

HEART PROBLEMS:	mitral valve prolapse, heart attack, high blood pressure, chest pains, heart murmur, artifical heart valve
LUNG PROBLEMS:	TB, pneumonia, emphysema, shortness of breath, asthma
LIVER PROBLEMS:	jaundice, hepatitis
KIDNEY OR URINARY PROBLEMS:	kidney stones, infection
ENDODRINE DISORDER:	hypo or hyperthyroidism, Addison's disease
DISEASE OF THE GASTROINTESTINAL TRACT:	ulcers, diverticulitis, colitis

BLEEDING DISORDER CANCER ARTHRITIS ANEMIA AIDS STROKE

DIABETES EPILEPSY CANCER RHEUMATIC OR SCARLET FEVER ARTIFICIAL HIP JOINTS

11. **Review of Systems:** Do you have now or have you had within the past year?

Weight change…….. no yes	Swollen feet/ankles…….. no yes	Seizures…….. no yes
Dry eyes…….. no yes	Skin rash…… no yes	Joint or muscle pain…... no yes
Chronic cough…… no yes	Chronic diarrhea……... no yes	Swollen lymph nodes…. no yes
Chest pain…….. no yes	Jaundice……. no yes	Easy bleeding……. no yes
Rapid heart beat…… no yes	Depression……. no yes	Easy bruising…….. no yes

12. **Social History:**

Are you in a high risk group for HIV……YES NO

Do you smoke……YES NO If so, how much?

Do you drink alcohol…… YES NO If so, what kind (beer vs hard liquor) and how much?

Release and Assignment - I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to my physicians. A photocopy of this document shall be as valid as the original.

Signature_____Date_____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signed_____

Date_____