Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

NEW PATIENT QUESTIONNAIRE: MEDICAL HISTORY

Plastic and Reconstructive Surgery

Date: _____ / _____ / _____ Age: _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other: ____________ Sex Assigned at Birth: ☐ Male ☐ Female

Preferred Name: ______________________ Preferred Pronoun: ☐ He ☐ She ☐ They ☐ Other: ______________

Primary Care Provider / Address: ____

Referring Provider / Address: ____

Reason for today's visit: ____

Current job: ______________________________ ☐ N/A Email: ______________________

Pharmacy / Address: ______________________________ Pharmacy Phone: (   ) _____ - ________

Is today's visit the result of an injury? ☐ No ☐ Yes

If Yes, Date of injury: _____ / _____ / _____

Type of injury: ☐ Work-related ☐ Automobile ☐ Other (describe): ______________________

Are you currently represented by an attorney? ☐ No ☐ Yes Name: ______________________

ALLERGY ☐ **No, I have no allergies or sensitivities that I know of.** ☐ **Yes If Yes,** list below.

	Allergy / Sensitivity / Medication Reaction:	**Type of Reaction:**
Medication:		
Vaccination:		
Contrast dye:		
Latex:		
Food / shellfish:		
Seasonal:		
Environmental:		
Insects / venom: (example: bee sting)		
Other:		

Complete only if you are being seen for breast-related or abdominal problems: ☐ N/A

If N/A, skip to **MEDICAL HISTORY**.

Have you had a mammogram or breast MRI? ☐ No ☐ Yes

If Yes to either, most recent Date: _____ / _____ / _____ Where was it done: ______________________

Results of most recent mammogram or breast MRI: ______________________

Have you had a breast biopsy? ☐ No ☐ Yes

If Yes, most recent Date: _____ / _____ / _____ Where was it done: ______________________

Results of most recent breast biopsy: ______________________

Do you have breast lump or discharge? ☐ No ☐ Yes Age of first period: _____ ☐ N/A

Number of pregnancies: _____ ☐ N/A Number of children: _____ ☐ N/A Number of C-sections: _____ ☐ N/A

Did you breastfeed? ☐ No ☐ Yes Bra size: _____ ☐ N/A

PATIENT QUESTIONNAIRE: MEDICAL HISTORY

DATE: ____/____/____

PATIENT NAME: ______________________________ **MRN:** ______________

MEDICAL HISTORY

Have you had any of the following? Check either "**No**" or "**Yes**" for each item.

	No	Yes		No	Yes
HIV / AIDS	☐	☐	Diabetes	☐	☐
Skin cancer	☐	☐	Asthma	☐	☐
Cancer (other)	☐	☐	Heart murmur	☐	☐
Type: ______________			Anemia	☐	☐
Rheumatic fever	☐	☐	Mitral valve prolapse	☐	☐
Tuberculosis	☐	☐	Stroke	☐	☐
Thyroid disease	☐	☐	Hepatitis	☐	☐
History of DVTs (blood clots)	☐	☐	Bleeding problem	☐	☐
High blood pressure	☐	☐	Blood transfusion	☐	☐
Arthritis	☐	☐	Glaucoma	☐	☐
Heart disease	☐	☐	History of miscarriages	☐	☐
Kidney disease	☐	☐			

	No	Yes
History of pacemaker use **or** automatic implantable cardioverter defibrillator	☐	☐
History of blood thinner use (example: Aspirin, Plavix®, Coumadin®, Xarelto®, Pradaxa®, Eliquis®, etc.)	☐	☐

SURGICAL HISTORY

Have you ever had any operations or surgical procedures? ☐ **No** ☐ **Yes** **If Yes,** list below.

Date:	Operation / Procedure:	Date:	Operation / Procedure:
____/____/____		____/____/____	
____/____/____		____/____/____	
____/____/____		____/____/____	
____/____/____		____/____/____	

MEDICATION

☐ **I take no medications or supplements.** ☐ **See attached list.**

List all the prescription and over-the-counter medications that you take at home (such as cold medication, herbals, vitamins, nutritional supplements or hormones). If you have received a printed medication list, please add here anything that is not on your printed list.

Also include your current medication(s) for blood thinners.

Medication / Supplement Name:	Dose:	How you take it: (by mouth, injection, etc.)	Time of day / How often:	Why you take it:

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Plastic and Reconstructive Surgery

MR2857

FAMILY HISTORY

Have any of your blood relatives had the following?

	Unknown	No	Yes	**If Yes**, explain who:
Breast cancer	☐	☐	☐	: ______
Ovarian cancer	☐	☐	☐	: ______
Melanoma	☐	☐	☐	: ______
High blood pressure	☐	☐	☐	: ______
Depression	☐	☐	☐	: ______
Heart disease	☐	☐	☐	: ______
Stroke	☐	☐	☐	: ______
Diabetes	☐	☐	☐	: ______
Kidney disease	☐	☐	☐	: ______
DVTs (blood clots)	☐	☐	☐	: ______

SOCIAL HISTORY

Smoking (Check all that apply):

☐ Never smoker ☐ Unknown if ever smoked ☐ Smoker, current status unknown
☐ Former smoker ☐ Current smoker, some days ☐ Current smoker, everyday
☐ Heavy tobacco smoker (More than 10 per day) ☐ Light tobacco smoker (Less than 10 per day)

Do you use any nicotine products? ☐ No ☐ Yes **If Yes**, check all that apply:

☐ Patches ☐ Gum ☐ Vape ☐ E-cigarettes ☐ Hookah ☐ Other: ______

Alcohol: Do you drink alcohol? ☐ No ☐ Yes **If Yes,** how many drinks per week: ____ For how many years: ____

REVIEW OF SYSTEMS

Have you had any of the following symptoms *within the past 3 months*?
Check either "**No**" or "**Yes**" for each symptom below.

Constitutional	**No**	**Yes**
Fever	☐	☐
Excessive fatigue (tired all the time)	☐	☐
Unexplained weight loss / gain	☐	☐
Gastrointestinal	**No**	**Yes**
Blood in your stool	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Heartburn	☐	☐
Psychiatric	**No**	**Yes**
Anxiety	☐	☐
Depression	☐	☐

Respiratory	**No**	**Yes**
Chronic (constant) cough	☐	☐
Wheezing	☐	☐
Genitourinary	**No**	**Yes**
Pain with urination	☐	☐
Difficulty with the stream of your urine	☐	☐
Musculoskeletal	**No**	**Yes**
Chronic muscle pain	☐	☐
Joint pain or swelling	☐	☐
Skin / Breast	**No**	**Yes**
Breast pain or lump	☐	☐
Skin rash	☐	☐

PATIENT QUESTIONNAIRE: MEDICAL HISTORY

DATE: ____ / ____ / ____

PATIENT NAME: ______________________ MRN: ______________

REVIEW OF SYSTEMS CONTINUED

Have you had any of the following symptoms *within the past 3 months*? Check either "**No**" or "**Yes**" for each symptom below.

Eyes	**No**	**Yes**
Blurry vision	☐	☐
Dry eyes	☐	☐
Ears, Nose, Throat and Mouth	**No**	**Yes**
Hearing loss: ☐ Left ☐ Right ☐ Both	☐	☐
Ringing of the ears: ☐ Left ☐ Right ☐ Both	☐	☐
Cardiovascular	**No**	**Yes**
Chest pain	☐	☐
Heart attack	☐	☐
Irregular heart beat / pulse	☐	☐
Swelling in the hands or feet	☐	☐

Neurological	**No**	**Yes**
Numbness	☐	☐
Seizures	☐	☐
Tingling	☐	☐
Endocrine	**No**	**Yes**
Abnormal milk production ☐ N/A	☐	☐
Tremor (shaking)	☐	☐
Hematologic / Lymphatic	**No**	**Yes**
Easy bruising / bleeding	☐	☐
Swollen lymph nodes	☐	☐
Allergic / Immunologic	**No**	**Yes**
Frequent and unusual infections	☐	☐

Patient Certification: I have answered these questions to the best of my ability. I understand that this information will be used to guide my care.

X ______________________ ______________________ **OR**
Patient's Signature Print Name

X ______________________ ______________________ **and** ______________
Signature of Person authorized to sign for patient Print Name Relationship to patient

Date: ____ / ____ / ____ **Time:** __ __ : __ __ ○ a.m. ○ p.m.

THIS SECTION TO BE COMPLETED BY MEDICAL ASSISTANT

Height: ________ in **Weight:** ________ lbs **BP:** ________ **Pulse:** ________ **BMI:** ________

X ______________________ ______________________ ____ / ____ / ____ __ __ __ __
Signature of Medical Assistant Print Name Date Time (24 hour)

Clinician Review: I have reviewed the above information with the patient.

INTERPRETER (if applicable) – Name or ID #: ______________________

X ______________________ ______________________ ____ / ____ / ____ __ __ __ __
Circle: M.D. / N.P. / P.A. - Signature Print Name Date Time (24 hour)

Beth Israel Deaconess
Medical Center

A teaching hospital of
Harvard Medical School

PLACE PATIENT MRN LABEL HERE

Should include: name, medical record number, barcode, and date

ADVERSE EFFECTS OF SMOKING & NICOTINE

Please be advised that smoking, exposure to secondary smoke, and the use of any product containing nicotine can have an adverse affect on the outcome of your plastic surgery procedure(s). Exposure to smoke and nicotine causes constriction of blood vessels that reduces the supply of oxygen and nutrients to tissues throughout the body. This results in damaging effects on the heart, lungs, blood vessels, and immune system that decrease your chance for a successful outcome after surgery.

Exposure to smoke or nicotine greatly increases your risk for poor wound healing, delayed wound healing, wound infection, adverse scarring, or complete skin loss. Exposure is also associated with an increased risk of deep tissue injury including potential fat, muscle or bone loss. The development of these complications following your procedure(s) may necessitate further surgery.

Please refrain from smoke and nicotine exposure for at least four weeks before and after your plastic surgery procedure(s). If you need assistance in becoming smoke-free, the American Lung Association offers a 7-step program as well as online support.

The American Lung Association
61 Broadway, 6th Floor
New York, NY 10006

1-800-LUNGUSA

http://www.lungusa.org

Patient Signature: ______________________________

Date: ______________________________

Authorization for Use of Medical Photographs
Department of Surgery – Division of Plastic Surgery

Patient Name:______________________________
Medical Record #: _________________________
Date: ___________________________________

OR:

PLACE PATIENT MRN LABEL HERE

Should include: name, medical record number, barcode, and date

Internal Use of Images

I, ___________________________ (check one) ☐**DO** ☐**DO NOT** authorize the Division of Plastic Surgery to use images and/or recordings regarding my case as a reference for current and prospective patients who are interested in having or may be having a similar procedure. The purpose of this disclosure is to assist current and future patients to evaluate the potential outcomes of such a procedure(s). The images and/or recordings may be used either in print form or posted on the Division of Plastic Surgery's website. I understand that only the images and/or recordings will be printed or posted, and will not be accompanied by any other personal information, such as my name or date of birth. This authorization will remain in effect until such images and/or recordings are removed from the Division of Plastic Surgery's website and photo book or until I revoke my authorization in writing.

Patient Rights

You have the right to revoke this authorization, in whole or in part, at any time by contacting the Division of Plastic Surgery in writing. Treatment will *not* be conditioned upon my authorization of any or all of the above described disclosures. Whether or not you agree to allow the Division of Plastic Surgery to use and/or disclose your images and/or recordings in the manners described, you will receive the same medically appropriate treatment that is afforded to all patients. When protected health information is disclosed, there is the potential that the recipient of that disclosure will re-disclose the protected health information. Such re-disclosures are not governed by HIPAA and any rights you may have under HIPAA will not apply to re-disclosures.

____

Patient's Signature **Date**

Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

MR0446

GENERAL AGREEMENT

General Information:

I request care from one or more of the following organizations, for treatment of my medical and/or mental health condition, and/or for the routine or intensive care of my child:

- Beth Israel Deaconess Medical Center (BIDMC)
- Harvard Medical Faculty Physicians at BIDMC (HMFP)
- Beth Israel Deaconess Healthcare (BID-Healthcare)

This care may include medical tests, exams, or treatments that are needed for my (my child's) condition.
I agree to this treatment and care.

Use and Disclosure of Medical Information:

BIDMC, HMFP, and BID-Healthcare may disclose to others and request from others my medical information. My information may be shared for treatment, healthcare operations, and payment purposes. Information shared may include information about my mental health or substance abuse treatment, but only the information necessary to coordinate my care.

- I agree to the sharing of my medical and mental health information for treatment, healthcare operations and payment purposes.
- I agree to let BIDMC, HMFP, and BID-Healthcare share information about my mental health or substance abuse treatment with other providers to coordinate my care.
- I have the right to request a restriction or limitation on how my medical or mental health information is used or shared. I understand that these organizations may not be able to act on all of my requests.
- I have the right to take back my consent, in writing, except when my consent has already been acted upon.

Insurance and Payment Information:

BIDMC, HMFP, and BID-Healthcare receive payment from insurance companies, Medicare, and/or other third party programs.

- I agree to let my doctor(s) and/or BIDMC submit claims and treatment information to my insurance program (private insurance, Medicare, etc.) for payment and to evaluate the quality of care I receive.
- I agree to have my insurance program make payments directly to BIDMC, HMFP, and BID-Healthcare.
- I understand that I must pay all charges, co-payments, and deductibles that are not covered by my insurance program.
- I agree to let BIDMC, HMFP, and BID-Healthcare share information about my inpatient or outpatient mental health or substance abuse treatment with my insurance program for payment purposes.

Special Note about Mental Health Benefits:

I understand that if I am using my health insurance benefits to pay for mental health treatment, and/or substance abuse treatment, my insurance program may need some information from my clinician(s).
The information that insurance companies need for initial sessions of **outpatient** treatment is limited to diagnosis, and type of treatment. However, if my outpatient treatment is to go beyond those initial sessions, then my insurance company will need additional information. If I am going to receive mental healthcare as an outpatient, I understand that my insurance company may have limits on the number of visits that it will pay for. I need to stay informed of my plan's mental health benefits.

If I am going to receive mental health treatment as an **inpatient**, my insurer will request information from my clinicians about my hospitalization. This additional information allows my insurer to determine if the treatment is medically necessary and if payment for treatment will be authorized.

Please continue on the reverse side.

Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

GENERAL AGREEMENT

- continued -

Durable Medical Equipment: Durable Medical Equipment (DME) is medical equipment to be used outside the hospital and at home. Examples of DME include nebulizers, wheelchairs and blood pressure monitors. I understand that it is my responsibility to obtain any DME that my healthcare professional says that I need. I am responsible for any and all costs not covered by insurance.

Release of Liability for Retention of Valuables: I understand that it is not wise to keep personal valuables with me while I am in the Medical Center. I understand that the BIDMC staff is willing to keep my valuables safe by placing them in a secure location while I am in the Medical Center. I understand that if I keep my valuables with me, and they are either stolen or lost, BIDMC does not have any liability and they will not reimburse me for the item(s).

The Healthcare Team: Beth Israel Deaconess Medical Center is a teaching facility. I understand that treatment and care will be provided by a team of healthcare providers headed by a staff doctor. I understand that this healthcare team may include resident doctors, nurses, and clinical students / staff. These healthcare team members may also watch or take part in my treatment and care.

Instructions for Patients: Please sign sections **A** and **B.**

A. General Information: I have read this form and I understand what it says. All of my questions have been answered in a language that I understand. I agree with the information on this form.

X______________________________ ______________________________ **OR**
Patient's Signature — Print Name

X______________________________ ______________________________ and ______________
Signature of Person authorized to sign for patient — Print Name — Relationship to patient

Date: ____/____/____ **Time:** __ __ : __ __ ○ a.m. ○ p.m.

B. Privacy Notice: I have received copies of the BIDMC "Notice of Privacy Practices" and "Your Rights and Responsibilities as a Patient". BIDMC has the right to change privacy practices. Any changes will be effective for medical information BIDMC already has about me as well as information BIDMC receives in the future. I am aware that I may request an additional or revised copy of "Notice of Privacy Practices".

X______________________________ ______________________________ **OR**
Patient's Signature — Print Name

X______________________________ ______________________________ and ______________
Signature of Person authorized to sign for patient — Print Name — Relationship to patient

Date: ____/____/____ **Time:** __ __ : __ __ ○ a.m. ○ p.m.

INTERPRETER (if applicable) – Name or ID Number: ______________________________