Riverside Plastic Surgery
Brent Moister, MD

FOR OFFICE USE

BP:	O2:	Height:
HR:	RR:	Weight:

DATE:_____

Name: _____

Address: _____

City, State, Zip: _____

Birth Date: _____Age: _____ SSN: _____

Primary Phone: _____ Type: Home / Work / Cell / Other_____

Secondary Phone:_____ Type: Home / Work / Cell / Other_____

Email: _____

Would you like access to our patient portal to send/receive secure messages with our staff? ___Yes ___No

Preferred method of contact: ___ Phone ___Email via patient portal

How would you like to receive appointment reminders? ___Text ___Phone ___Email

Preferred Pharmacy: _____

Do you give us consent to retrieve your medication history from your pharmacy? _____Yes _____No

Reason for visit today: _____

Doctor or person who referred you to see Dr. Moister: _____

Social History

Marital Status: ___Married ___Single ___Divorced ___Widowed

Occupation: Current employment status: ___Employed ___Unemployed ___Retired ___Homemaker

. Occupation:_____ Employer_____

Are you being seen today for a work related injury? ___Yes ___No

Disability: Are you disabled? ___No ___Yes Reason:_____

Have you used any of the following substances?

Substance	Currently Use?	Previously Used?	Type/Amount/Frequency	How long? (Years)	If stopped, when? (Year)
Tobacco	__Yes __No	__Yes __No			
Alcohol (beer, wine, liquor)	__Yes __No	__Yes __No			
Recreational/Street drugs	__Yes __No	__Yes __No			

Past Medical History

Please indicate if you have **EVER** had any of the following:

General:		**Comments**	**Genitourinary:**		**Comments**
Recent weight change	Y / N	Amount: gain / loss	Incontinence/leaking	Y / N	
Cancer	Y / N		Kidney Stones	Y / N	
Type:			Kidney disease	Y / N	
Eyes:			**Musculoskeletal:**		
Glasses/contacts	Y / N		Arthritis	Y / N	
Glaucoma	Y / N		Gout	Y / N	
Cataracts	Y / N		Broken Bones	Y / N	
Ears/Nose/Throat:			Amputation	Y / N	Where:
Hearing loss	Y / N		**Skin:**		
Nosebleeds	Y / N		Non healing wound/lesion	Y / N	
Cardiovascular:			Skin Cancer	Y / N	
High Blood Pressure	Y / N		**Breasts:**		
High Cholesterol	Y / N		Breast Mass	Y / N	
Heart Murmur	Y / N		Breast Biopsy	Y / N	
Irregular Heart Beat	Y / N		Abnormal Mammogram	Y / N	
Angina	Y / N		Breast Cancer	Y / N	
Heart attack	Y / N		**Neurologic:**		
Pacemaker	Y / N		Stroke	Y / N	
Congestive Heart Failure	Y / N		Dementia/Alzheimers	Y / N	
Peripheral Artery Disease	Y / N		Parkinsons	Y / N	
Respiratory:			Seizures	Y / N	
Asthma	Y / N		Traumatic Brain Injury	Y / N	
Tuberculosis (TB)	Y / N		**Psychiatric:**		
COPD/Emphysema	Y / N		Depression	Y / N	
Gastrointestinal:			Anxiety	Y / N	
Peptic Ulcer Disease	Y / N		Bipolar Disorder	Y / N	
Reflux (GERD)	Y / N		**Endocrine:**		
Hepatitis	Y / N		Diabetes	Y / N	___Type I ___Type II
Liver Disease/Cirrhosis	Y / N		Thyroid problems	Y / N	___High ___Low
Gallstones	Y / N		**Hematologic:**		
Allergic/Immunologic:			Anemia	Y / N	
HIV/AIDS	Y / N		Bleeding disorder	Y / N	
Fibromyalgia	Y / N		Pulmonary Emboli (lung)	Y / N	
Lupus	Y / N		DVT (clot in leg)	Y / N	
Rheumatoid Arthritis	Y / N		Aspirin/Blood Thinners	Y / N	

Please list any other medical conditions in addition to those listed above

_____ _____

_____ _____

_____ _____

Please list any physicians whom you see on a regular basis so we may coordinate care if needed

Primary Care_____ Oncologist_____

Cardiologist_____ Surgeon_____

Pulmonologist (lung)_____ Other_____

Past Surgical History

Please list any surgical procedures you have had

Procedure	Year	Comments

Medications

Please list any medications you are currently taking. Include any other the counter medicines as well as vitamins/supplements.

Medication	Dose	Frequency	Comments

Are you allergic to any drugs that know of? ____Yes ____No If yes please indicate drug and reaction.

Drug	Reaction

Review of Systems

Please indicate if you have experienced any of the following symptoms within the **PAST MONTH**

General:		**Comments**	**Allergic/Immunologic:**		**Comments**
Fever/chills	Y / N		Hives	Y / N	
Night sweats	Y / N		Seasonal allergies	Y / N	
Weight change	Y / N		HIV exposure	Y / N	
Fatigue/somnolence	Y / N		**Genitourinary:**		
Change in appetite	Y / N		Pelvic pain	Y / N	
Eyes:			Frequency/burning/urgency	Y / N	
Change in vision	Y / N		Blood in urine	Y / N	
Double vision	Y / N		Urinary incontinence	Y / N	
Eye pain	Y / N		Testicular pain/swelling	Y / N	
Red eye	Y / N		**Musculoskeletal:**		
Ears/Nose/Mouth/Throat:			Joint pain/swelling	Y / N	
Ear pain	Y / N		Bone pain	Y / N	
Ear discharge	Y / N		Muscle pain	Y / N	
Hearing loss	Y / N		**Skin:**		
Tinnitus (ringing)	Y / N		New rashes/moles	Y / N	
Nasal bleeding	Y / N		Nonhealing skin lesion	Y / N	
Nasal discharge	Y / N		Itching	Y / N	
Sinus pressure	Y / N		**Breasts:**		
Sore throat	Y / N		New lump/mass	Y / N	
Oral sores	Y / N		Breast pain	Y / N	
Tooth pain	Y / N		Nipple discharge	Y / N	
Hoarseness	Y / N		**Neurologic:**		
Neck pain	Y / N		Headache	Y / N	
Cardiovascular:			Muscle weakness	Y / N	
Chest pain	Y / N		Numbness/tingling	Y / N	
Palpitations	Y / N		Memory loss	Y / N	
Leg swelling (edema)	Y / N		Seizures	Y / N	
Leg pain with walking	Y / N		Dizziness/Fainting	Y / N	
Respiratory:			**Psychiatric:**		
Shortness of Breath	Y / N		Anxiety	Y / N	
Cough	Y / N		Depression	Y / N	
Wheezing	Y / N		Insomnia	Y / N	
Hemoptysis (blood)	Y / N		**Endocrine:**		
Gastrointestinal:			Heat intolerance	Y / N	
Nausea/vomiting	Y / N		cold intolerance	Y / N	
Diarrhea/constipation	Y / N		Excessive hunger/thirst	Y / N	
Abdominal pain	Y / N		**Hematologic/Lymphatic:**		
Bright red stools	Y / N		Enlarged lymph nodes	Y / N	
Tarry stools	Y / N		Easy bruising	Y / N	
Stool incontinence	Y / N		Easy bleeding	Y / N	