Patient Intake Information

Date: ____________________ DOB: __________________

Reason for Consultation: ____

Last Name: ____________________ First Name: _____________________ Middle: ___________________

Height: ________________ Weight: ________________

Phone Number: ______________________ Do you authorize our office to send text messages □ Yes □ No

E-Mail address: _________________________ Do you authorize our office to send E-Mail □ Yes □ No

Social Security: ________-______-________

Address: ________________________________ City: __________________________ Zip: ______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouses Name: ______________________________ Spouses Phone Number: ________________________

In case of emergency, who may we contact? ____

Contact Phone Number: ___________________________ Relationship: ______________________

Do you grant our office authorization to discuss any **protected health** information regarding your care with another individual? (spouse, significant other, etc.) □ Yes □ No

If yes, please provide the information regarding that individual (if different than listed above):

Name: ____ Relationship: _______________________

Please be advised that any person not listed will NOT be given any information regarding your care. Any person listed WILL have access to information about your care. You may make changes to your emergency contact person at any time

Preferred Pharmacy Name/City: ____

Phone Number: ______________________________

Referral Source

Who may we thank for your referral?

☐ Physician: ______________________________

☐ Friend or family member: ______________________________

☐ Our Website (DrTabbal.com)

☐ Newspaper/Magazine

☐ Internet or Social Media: ☐ Google ☐ Facebook ☐ Instagram

☐ Other: ______________________________

Would you like to subscribe to our practice newsletter? ☐ Yes ☐ No

Personal Health Habits

List any skincare products you use: ______________________________

Do you apply sunscreen regularly? ☐ Yes ☐ No

Do you exercise routinely? ☐ Yes ☐ No

If yes, please list what type of exercise and how frequent: ______________________________

____

Do you currently or have you ever used any type of nicotine products? ☐ Yes ☐ No

If yes, please list what product type, frequency and duration of use, date of abstinence:

____

Do you consume alcohol? ☐ Yes ☐ No

If yes, how many beverages? __________ ☐ Weekly ☐ Monthly

Do you currently use any recreational drugs? ☐ Yes ☐ No

If yes, please list: ____

Please list all prescription and/or non-prescription medications? (including herbs, supplements, vitamins, over the counter medications, etc.)? If so, please list: ☐ None

1) ____________________ 2) ____________________ 3) ____________________

4) ____________________ 5) ____________________ 6) ____________________

Do you currently have any medical conditions? ☐ Yes ☐ No

What, if any, medical conditions do you have? ______________________________

____

Have you had any of the following within the last year? ☐ None

Chest Pain	Yes	No	Dry Eyes	Yes	No	Weight Change	Yes	No
Swollen Feet/Ankles	Yes	No	Joint/ Muscle Pain	Yes	No	Chronic Cough	Yes	No
Abnormal Heartbeat	Yes	No	Depression	Yes	No	Chronic Diarrhea	Yes	No
Easy Bleeding	Yes	No	Swollen Lymph Nodes	Yes	No	Jaundice	Yes	No
Easy Bruising	Yes	No	Seizures	Yes	No	Skin Rash	Yes	No

If not listed, please list: ____

Have you had any of the following in the past? ☐ None

Stroke	Yes	No	Cancer	Yes	No	Radiation Treatment	Yes	No
Asthma	Yes	No	MRSA Exposure	Yes	No	Facial Implants	Yes	No
High Blood Pressure	Yes	No	AIDS or HIVS	Yes	No	Diabetes	Yes	No
Heart Disease	Yes	No	Hepatitis	Yes	No	Kidney Disease	Yes	No
Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No	Glaucoma	Yes	No
Rheumatic Fever	Yes	No	Stomach Ulcer	Yes	No	Blood Clots	Yes	No
COVID	Yes	No	Thyroid Disease	Yes	No	COPD	Yes	No

If not listed, please list: ____

Allergies

Do you have any known allergies to any medications, food, adhesive, and/or latex? ☐ Yes ☐ No

Substance: ______________________ Reaction: ______________________

Substance: ______________________ Reaction: ______________________

Substance: ______________________ Reaction: ______________________

Substance: ______________________ Reaction: ______________________

Substance: ______________________ Reaction: ______________________

Surgery & Cosmetic Surgery/Procedure History

Please list any past surgery and cosmetic surgery/procedures that you have undergone:

Surgery: ____ Date: ________________

Surgery: ____ Date: ________________

Surgery: ____ Date: ________________

Surgery: ____ Date: ________________

Have you, or any family member(s), had previous surgical complications or reactions to general anesthesia? ☐ Yes ☐ No

If so, please explain: ____

____

Have you formed excessive/unsatisfactory scars or keloids in the past? ☐ Yes ☐ No

Breast & Body

*Please answer the questions below **ONLY** if you wish to discuss breast surgery*

Has your weight fluctuated by 15 lbs. or more in the last year? ☐ Yes ☐ No

Do you plan to lose more weight in the future? ☐ Yes ☐ No

Current bra/cup size: ____________________ Goal bra/cup size: ____________________

Total number and age of children: ____

Delivery method: ☐ Vaginal Delivery ☐ Caesarean Section

Did you breast feed? ☐ Yes ☐ No

Please list your children's ages: ____

Do you plan on having more children? ☐ Yes ☐ No

What was the largest bra size you reached during pregnancy or breastfeeding? ____________

Bra size prior to first pregnancy? ____

Do you have a personal or family history of breast cancer and/or breast disease? ☐ Yes ☐ No

If yes, please explain (disease, relation to relative, age of diagnosis): ________________

____

Have you ever had a mammogram in the past? ☐ Yes ☐ No

If yes, when? ____

____

Have you have had an abnormal mammogram? ☐ Yes ☐ No

If yes, please explain: ____

____

Face and Rhinoplasty (Nasal) Surgery

*Please answer the questions below **ONLY** if you wish to discuss face/neck and/or nasal surgery*

Do you have a history of dry eyes? ☐ Yes ☐ No

If yes, which if any medications (including over the counter) do you use? ____________

____

Have you suffered any nasal trauma in the past? ☐ Yes ☐ No

If yes, please explain: ____

Do you suffer from nasal airway obstruction? ☐ Yes ☐ No

If yes, have you ever been treated? ____

Have you had Botox in the past? ☐ Yes ☐ No

If yes, when was your last treatment? ____

Have you ever used fillers and/or other injectable products in the past? ☐ Yes ☐ No

If yes, when and what was your last treatment? _________________________________

I verify that the above information is true and accurate to the best of my knowledge.	Reviewed and amended.
Patient's Signature:	**Dr. Tabbal's Signature:**