Datamatrix 2D barcode

BRIGHAM AND WOMEN'S HOSPITAL
A Teaching Affiliate of Harvard Medical School
75 Francis Street, Boston, Massachusetts 02115

PATIENT IDENTIFICATION AREA

Division of Plastic Surgery

Patient Medical Data Sheet

Patient Demographics

Name: _____ Date of Birth: _____ Age: _____ Height: _____ Weight: _____
Occupation: _____ Are you pregnant? ☐ No ☐ Yes ☐ N/A
Reason for today's visit (please be specific): _____
Is this health issue due to an accident? ☐ No ☐ Yes Date: _____ ☐ Auto ☐ Work ☐ Other: _____

Medical History *(please check/discuss past or current medical conditions)*

☐ Anemia/Bleeding/Clotting	☐ Gastrointestinal Problems	☐ Liver Disease
☐ Anxiety/Depression	☐ Heart Attack	☐ Lupus/Scleroderma/Vasculitis
☐ Arthritis	☐ Heart Disease/Murmur	☐ Neurological Disease
☐ Asthma/Breathing Problem	☐ Hepatitis	☐ Seizures
☐ Back or Joint Problems	☐ High Blood Pressure	☐ Stroke
☐ Cancer/Tumor	☐ High Cholesterol	☐ Skin Lesion(s)
☐ Diabetes/Thyroid	☐ HIV/AIDS	☐ Wound(s)
☐ Eating/Appetite/Weight Loss	☐ Inflammatory Bowel Disease	☐ Other Issues _____
☐ Eye/Vision Problem	☐ Kidney/Bladder Disorders	

Family history: _____ ☐ None
Allergies: _____ ☐ None
Past surgeries: _____ ☐ None
Date of last mammogram: _____ ☐ None
Current medications and dosages: _____
_____ ☐ None
☐ Please check here if you have been diagnosed with MRSA, VRE, or C. diff, or been placed on "contact precautions"

Please answer the following questions:

Do you smoke or use tobacco products? ☐ No ☐ Yes How much? _____
Do you drink alcohol? ☐ No ☐ Yes How much? _____
Do you currently use any unprescribed drugs (ex: marijuana, cocaine, etc.) ☐ No ☐ Yes How much? _____
Have you ever been hurt or threatened by someone you care about? ☐ No ☐ Yes
Do you have difficulties with: ☐ Eating ☐ Dressing ☐ Hygiene ☐ Walking ☐ Toileting ☐ Getting in/out of bed
Do you have a history of falls? ☐ No ☐ Yes If yes, how did they happen: _____
Do you experience pain as part of your daily life? ☐ No ☐ Yes
Rate your pain: _____ (0 = none; 2 - 3 = slight; 7 - 8 = moderate; 10 = worst possible)
How do you treat this pain? ☐ Heat ☐ Ice ☐ Massage ☐ Medication ☐ Other _____
Have you lost or gained more than 10 pounds in the last three months without trying? ☐ No ☐ Yes
Do you have a health care proxy? ☐ No ☐ Yes
Did you receive a copy of the "We Care About Your Safety" brochure? ☐ No ☐ Yes
Do you understand how to prevent the spread of germs? ☐ No ☐ Yes

Date _____ Time _____ Patient Signature _____

Date _____ Time _____ Physician Signature _____ MD CID ☐☐☐☐☐