DR BRIAN BUINEWICZ
plastic surgery + wellmed spa

Patient Name: _____
First **Middle** **Last**

Address: _____
Street & Apartment # **City** **State** **Zip**

Age: _____ **DOB:** _____ **Identify as:** _____ **Marital Status:** _____

Home Phone: _____ **Cell Phone:** _____

Other phone: _____ **Email:** _____

Any restrictions for contacting you? YES NO Contact restrictions (if any): _____

I consent to receive a message via text, answering machine, voicemail, or email and for the office to leave a message with spouse, parent or other household member. (Circle one) YES NO

I consent to receive test results on my answering machine, by text, voicemail, or email and for the office to leave a message with a spouse, parent or other household member. (Circle one) YES NO

Primary Doctor: (Name) _____ **Phone:** _____

Pharmacy (Name and phone number): _____

How did you hear about Dr. Buinewicz?
_____

DR BRIAN BUINEWICZ
plastic surgery + wellmed spa

MEDICAL HISTORY FORM

Date of Birth: Age:

1. Please list all food and drug allergies.

2. Please list all medications you now take (including over the counter meds, i.e. aspirin).

3. Please list all operations you have had.

4. Please list your medical problems.

5. Please list your present height and weight. _____ ft _____ in & _____ lbs

HAVE YOU EVER HAD OR BEEN TOLD YOU HAVE ? (PLEASE CIRCLE IF YES)

1. A heart attack
2. Heart disease
3. Anemia
4. A heart murmur
5. Chest pain or angina

DR BRIAN BUINEWICZ
plastic surgery + wellmed spa

HAVE YOU EVER HAD OR BEEN TOLD YOU HAVE? (PLEASE CIRCLE IF YES)

6. High blood pressure
7. A stroke/mini stroke/TIA
8. Fainting episodes
9. Epilepsy/seizures/falling out
10. Shortness of breath when resting
11. Shortness of breath when climbing stair or walking
12. Shortness of breath at night
13. Asthma/emphysema/COPD-chronic obstructive pulmonary disease
14. Chronic bronchitis
15. Tuberculosis
16. An abnormal chest x-ray (specify)
17. Diabetes/trouble with your blood sugar
18. Kidney problems
19. Arthritis/joint problems
20. Heartburn/ulcer/hiatal hernia
21. Cancer (specify)
22. Chemotherapy (specify)
23. Liver problems/jaundice/hepatitis
24. Anemia/iron poor blood/low blood count
25. Bleeding tendencies
26. Thyroid problems
27. A significant weight loss_____

DR BRIAN BUINEWICZ
plastic surgery + wellmed spa

HAVE YOU EVER HAD OR BEEN TOLD YOU HAVE? (PLEASE CIRCLE IF YES)

28. Mental/emotional/nervous disorders

29. Eye problems

HAVE YOU EVER HAD OR BEEN TOLD YOU HAVE? (PLEASE CIRCLE IF YES)

30. Frequent headaches/migraines

31. A problem with anesthesia

32. Hepatitis

33. HIV

34. could be pregnant

35. Have bridgework, dentures, chipped or loose teeth, caps, braces

DO YOU/ HAVE YOU EVER …

36. Smoke cigarettes

37. Drink alcohol

38. Do you use marijuana or THC product?

39. Do you use any vaping device?

I certify that the above information is true and correct to the best of my knowledge.

_____ _____

Patient/guardian **Date**

_____ _____

Reviewed by **Date**