GROSSMAN | CAPRARO
plastic surgery

4600 Hale Parkway, Suite 100, Denver, Colorado 80220
7447 E. Berry Avenue, Suite 160, Greenwood Village, Colorado 80111
Phone: 303-320-5566 or 800-394-0010 Fax: 303-320-1453

# patient information

date: _____

surgeon: ☐ john a. grossman, m.d. ☐ matthew b. baker, m.d.
☐ philippe a capraro, m.d. ☐ teresa c. cunningham, m.d.

name: _____ social security #: _____

street address: _____ email: _____

city: _____ state: _____ zip: _____

home phone: _____ work phone: _____ cell phone: _____

may we contact you: at home? y / n at work? y / n on your cell? y / n by email? y / n

date of birth: _____ age: _____ gender: ☐ f ☐ m marital status: ☐ m ☐ s ☐ d ☐ w

ethnicity: ☐ hispanic/latino ☐ non hispanic/latino language: ☐ english ☐ spanish ☐ other

race: ☐ african american ☐ caucasian ☐ hispanic ☐ asian ☐ decline to provide

profession: _____ employer: _____

reason for consultation: _____

referred by: _____

do you intend to bill medical services to your insurance? ☐ yes ☐ no

please note: health insurance plans do <u>not</u> cover aesthetic surgery and procedures that are not considered medically necessary

## responsible party

please complete the following if you intend to bill your insurance or if someone other than the patient is responsible for payment

name: _____ social security #: _____

date of birth: _____ relationship to patient: ☐ self ☐ spouse ☐ parent ☐ other _____

street address: _____

city: _____ state: _____ zip: _____

home phone: _____ work phone: _____ cell phone: _____

employer: _____

health insurance plan: _____ phone #: _____

group policy #: _____ member id #: _____

## emergency contact

name: _____ relationship: _____

street address: _____

city: _____ state: _____ zip: _____

home phone: _____ work phone: _____ cell phone: _____

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John A. Grossman, M.D.
Philippe A. Capraro, M.D.
Matthew B. Baker, M.D.
Teresa C. Cunningham, M.D.

4600 Hale Parkway Suite 100
Denver, CO 80220
P:303-320-5566 F:303-320-1453
7447 E. Berry Ave Suite 160
Greenwood Village, CO 80111
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## PATIENT HEALTH INFORMATION

**NAME**: _____ Today's Date: _____
Last First MI

Date of birth: _____ Age: _____ SEX: Male / Female

**Primary Care Physician**: _____ Phone number: _____

Street address: _____

City: _____ State:_____ Zip: _____

**Referring Physician**: _____ Phone number: _____

Street address: _____

City: _____ State:_____ Zip: _____

---

### I. GENERAL

a. Specific reason(s) for which you are being seen (check all that apply):

| ☐ **Aesthetic Surgery** | | ☐ **Reconstructive Surgery** |
|---|---|---|
| ☐ Face | ☐ Small Breasts | ☐ Breast Reconstruction |
| ☐ Neck | ☐ Large Breasts | ☐ Skin Cancer/Lesion |
| ☐ Brow | ☐ Sagging Breasts | ☐ Facial/Nasal/Ear Injury |
| ☐ Eyes | ☐ Excess Truncal Skin | ☐ Scars |
| ☐ Nose | ☐ Abdomen | ☐ Burn Injury |
| ☐ Lips | ☐ Lower Extremity | ☐ Hand Injury |
| ☐ Ears | ☐ Buttocks | ☐ Wound Care |
| ☐ Wrinkles/Skin | ☐ Liposuction | ☐ ER Follow-up |
| | ☐ Other _____ | ☐ Other _____ |

b. Have you seen other doctors for this reason? ☐**Yes** ☐**No**
If so, who? _____

c. Have you been previously treated for this problem? ☐**Yes** ☐**No**

d. If so, please indicate:

| Year | Treatment/Procedure | Physician | Complications |
|---|---|---|---|
| | | | |

_____

_____

## II. PAST MEDICAL HISTORY

a. What is your present: Height: _____ Weight: _____

b. Please indicate if you HAVE or have HAD any of the following medical problems:

| | HAVE | HAD | COMMENTS/TREATMENT |
|---|---|---|---|
| High Blood Pressure | | | |
| Heart or Circulatory problems (eg. Chest pain/Heart Attack/ High cholesterol) | | | |
| Respiratory problems (eg. Asthma/Pneumonia/ Shortness of breath) | | | |
| Gastrointestinal Problems (eg. Ulcer/Hernia/Reflux) | | | |
| Genitounrinary Problems (eg. Voiding problems/ Menstrual problems/Impotence/Kidney stones) | | | |
| Endocrine/Immune Problems (eg. Thyroid problems/ Diabetes/HIV/AIDS/Lupus) | | | |
| Bleeding Problems (eg. Easy bruising/Clots/ Anemia) | | | |
| Musculoskeletal Problems (eg. Arthritis/Weakness/ Fibromyalgia/Limited mobility/Numbness/Tingling) | | | |
| Cancer (please indicate type) | | | |
| Eye Problems (eg. Dry eyes/Glaucoma/Tearing) | | | |
| Nasal Problems (eg. Bleeding/Sinusitis/Difficulty breathing/Runny nose) | | | |
| Neurological/Emotional Problems (eg. Headaches/ Seizures/Depression) | | | |

c. Please list any additional medical issues and any non-surgical hospitalizations or emergency room visits requiring treatment. (Please list additional problems on the last page.)

Year Problem Treating Physician

_____

_____

_____

## III. PAST SURGICAL HISTORY

a. Have you ever had surgery, including *Plastic Surgery*? ☐**Yes** ☐**No**

b. If you have had Plastic Surgery, please rate your results:

☐Excellent ☐Good ☐Fair ☐Poor

c. If your results were fair or poor, please describe briefly.

_____

_____

d. Please list all prior surgical procedures. (This includes removal of tonsils/appendix/gallbladder, LASIK surgery, wisdom tooth extraction, etc.) List additional surgeries on the last page.

| Year | Procedure | Surgeon | Complications |
|---|---|---|---|

_____

_____

_____

_____

_____

e. If you have had surgery, check type(s) of anesthesia you received and circle any problem(s).

☐ General Anesthesia Nausea/Vomiting/Slow awakening/Difficult entubation/Other _____

☐ IV Sedation Nausea/Vomiting/Slow awakening/Other _____

☐ Epidural/Spinal Nausea/Vomiting/Insufficient/Bleeding/Headache/Other _____

☐ Block (eg. Axillary, regional, etc.) Insufficient /Prolonged/Systemic reaction Other _____

☐ Local Insufficient block/Heart palpitations/Systemic reaction/Other _____

## IV. MEDICATIONS

a. Do you require antibiotics prior to surgery? ☐**Yes** ☐**No**

If so, why? _____

b. Do you take any medications <u>including vitamins</u>? ☐**Yes** ☐**No**

c. If so, please indicate.

| | Name | Dose |
|---|---|---|
| ☐ Blood pressure pills | _____ | |
| ☐ Water pills | _____ | |
| ☐ Blood thinners | _____ | |
| ☐ Steroids | _____ | |

☐ Insulin _____

☐ Hormone replacement therapy _____

☐ Vitamins (eg. B, C, E, K, etc.) _____

d. Please list ALL additional medications that you take. List additional medications on the last page.

| Medication | Dose | Why? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

e. Do you take any herbs, dietary supplements, or weight reduction products? ☐**Yes** ☐**No**
If so, please circle.

| | | | | |
|---|---|---|---|---|
| Echinacea | Ephedra ***(Ma Huang)*** | Feverfew | Garlic | Gingko |
| Ginseng | Goldenseal | Kave-kava | Licorice | METABO-life |
| St. John's Wort | Saw palmetto | Valerian | | |

Others _____

f. Do you take aspirin or ibuprofen products? ☐**Yes** ☐**No**
If so, please indicate.

☐ Aspirin (ASA/Bayer/Ecotrin/Excedrin/Fiorinal/etc)

☐ Ibuprofen (eg. Advil/Motrin/etc)

☐ Non-steroidal anti-inflammatories (eg. Aleve/Anapro/Daypro/Toradol/etc)

Others _____

## V. ALLERGIES & SENSITIVITIES

a. Medication Allergies or Sensitivities? ☐**Yes** ☐**No**
If so, please indicate drug and circle reaction(s).

☐ Penicillin Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other _____

☐ Sulfa Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other _____

☐ Morphine Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other _____

☐ Codeine Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other _____

| **Other Medication(s)** | **Reaction** |
|---|---|
| _____ | Rash/Hives/Anaphylaxis/Swelling/Nausea/Vomiting/Other _____ |
| _____ | Rash/Hives/Anaphylaxis/Swelling/Nausea/Vomiting/Other _____ |

b. Environmental or Food Allergies? ☐**Yes** ☐**No**

c. Latex Allergies? ☐**Yes** ☐**No**

d. Tape or Adhesive Sensitivities? ☐**Yes** ☐**No**

If so, please list type of tape or adhesive.

_____

## VI. SOCIAL HISTORY

a. ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

b. Children (birth years): _____

c. Do you smoke?/Have you ever smoked? ☐**Yes** ☐**No**
If yes, please indicate and circle appropriate reply:

_____ Cig's or Packs/Day _____ x Years Quit _____ weeks/months/years ago

d. Do you drink alcohol? ____ times/Day ____ times/Week ____ Rarely _____ Never

f. Do you drink caffeinated beverages? ☐**Yes** ☐**No** If yes: _____/Day

g. Do you use any recreational drugs? ☐**Yes** ☐**No**

## VII. FAMILY HISTORY

| Do you have a family history of: | | | Relationship | Problem |
|---|---|---|---|---|
| Heart problems | ☐**Yes** | ☐**No** | | |
| Diabetes | ☐**Yes** | ☐**No** | | |
| Breast cancer | ☐**Yes** | ☐**No** | | |
| Other cancers | ☐**Yes** | ☐**No** | | |
| Bleeding problems | ☐**Yes** | ☐**No** | | |
| Anesthesia problems | ☐**Yes** | ☐**No** | | |
| Other problems | ☐**Yes** | ☐**No** | | |

## VIII. ADDITIONAL INFORMATION

_____

_____

_____

_____

_____

**SIGNATURE**: _____