



Patient History Form

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Date: _____

Date of Birth: _____ **Age:** _____

Name: _____
Last First M.I.

How did you learn about Dr. Barone? _____

Primary Care Physician:

Name: _____

Address: _____

Office Telephone: _____ **FAX:** _____

Pharmacy:

Name: _____ **Telephone #:** _____

Address: _____

Social History:

Do you Smoke? YES NO

If yes, _____ # packs per day _____ # of years.

If you currently do not smoke when did you stop? _____

Do you drink Alcohol? YES NO If yes, how much? _____

Do you use Recreational Drugs?

Describe _____

Dr. Barone's Signature

Date

List ALL Medications you are taking or have taken within the last month (include aspirin, Motrin and herbal drugs):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List All Drug Allergies including Latex, if none write “NKDA”:

List ALL Surgical Operations and Hospitalizations you have ever had:

Date////////////////////////////////////	Date////////////////////////////////////

Dr. Barone’s Signature

Date



Medications to Avoid 3 weeks before Surgery

The following drugs will have an undesirable side affect and will cause abnormal bleeding during your surgery. This is NOT a complete list, so please inform Dr. Barone of All of the medicines you normally take. This includes over the counter drugs and cold medicines. If you need to take a medication for pain prior to surgery, you may take Tylenol.

Advil	Darvon Compound	Stendin
Aleve	Daypro	Stanback Powder/ Max Powder
Alka-Seltzer	Dristan	St. John's Wort
Alka_Seltzer Plus	Duragesic	Stero-Darvon with Aspirin
Anacin	Ecotrin	Supac
Anaprox	Empirin	Synalgos D.C.
Ansaid	Emprazil	Triaminicin
Argesic	Excedrin	Triagesic
Arthropan Liquid	Feldene	Ursinus Inlay Tabs
Ascodeen-30	Four Way Cold Tablets	Vanguish
Ascriptin	Fiorinal	Vioxx
Aspirin (all products)	Fish Oil	Vitamin E
Bayer Aspirin	Ginkgo Biloba	Vivo Med
BC Powders	Ibuprofen (Motrin)	Warfarin(Coumadin)
Buff-A-Comp	Measurin	***All Herbal Meds
Buffadyne	Midol	
Formula	Monacet with Codeine	
Bufferin	Momentum Muscular -	
Backache	Norgesic	
Butalbital	Pabirin Buffered Tablets	
Cama-Inlay Tabs	Panalgesic	
Cama Arthritis	Pain Reliever	
Caprin Capsules	Panadynes Analgesic	
Celebrex	Persistin	
Cheracol Capsules	Plavix	
Congespirin	Power Drinks	
Conaretol	Robaxisal	
Cope	Sine-Aid	
Coricidin	Sine-Off	
Dolia	Sinutab	
	SX-65 Compound Capsule	

I have read the above list, received a copy and have no further questions.

Patient

Date

Dr. Barone's Signature

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*****Copy to be given to patient*****

Review of Systems

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Check Yes or No by the current ailment as it applies to YOU. If unsure, place a question mark (?)

General

yes no

- Weight loss greater than 10 lbs in last year,
If Yes, how much? _____
- Fever
- Trouble Sleeping
- Poor Appetite

Eyes

- Glasses/Contacts
- Loss or Change of Vision
- Glaucoma or Cataracts
- Eye Surgery such as Lasix
- Dry Eyes
- Frequent use of Eyedrops

Ear, Nose and Throat

- Trouble breathing out of nose
- Nose bleeds
- Hearing Aids/Hearing loss
- Recurrent Ear Infections
- Sore throat/Strep Throat

Cardiovascular

- High Blood Pressure
- Heart Murmur
- Mitral Valve Prolapse
- Irregular heartbeat
- Previous Heart Attack
- Chest Pain
- Deep Vein Thrombosis (DVT)
- History of blood clots

Respiratory

- Shortness of Breath
- Asthma
If Yes, # times a week use an inhaler? _____
- History of Tuberculosis
- Chronic Cough
- Emphysema
- COPD (chronic obstructive pulmonary disease)
- History of Apnea
- Pulmonary Embolism (PE)

Gastrointestinal

- Ulcers
- History of Jaundice (yellow skin)
- History Cirrhosis
- History Gallstones

Females ONLY

yes no

- Prior Breast Biopsy
- Breast Lumps
- Bloody Nipple Discharge
- Abnormal Mammogram
Date of Last Mammogram _____
- Birth Control?
Method _____
- Family History Breast Cancer
- Are you pregnant?
- Will you have any more children?

Genitourinary

- Problems Urinating
- Difficulty starting stream
- Painful/Burning/Frequent Urination

Skin

- Skin Cancer
Where _____
- Problems with Scarring
Describe _____
- Ever use Accutane?
If Yes, when _____
- Bruise easily?

Neuro

- Blackouts/Fainting/Confusion
- Seizures

Psychiatric

- Severe Depression History
- Prior Counseling

Endocrine

- Diabetes
- Thyroid Problems

Allergy/Immunologic

- Latex Allergy
- HIV / AIDS
- Hepatitis ___A ___B ___C
- Food Allergies
- Use Recreational Drugs?

Hematologic/Lymphatic

- Bleeding Disorders
- Enlarged Lymph Nodes

Dr. Barone's Signature

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**Patient Photographic Authorization
and Release**

I, _____, authorize Dr. Constance M. Barone and/or Constance M. Barone, M.D., F.A.C.S. and her representative(s), to take photographs, slides and/or videotapes of me or parts of my body for the following procedure(s) and for medical purposes to be used for my care, medical presentation and/or articles.

I also authorize the use of these images, without compensation to me, for the following specific purposes: (Please initial in the boxes marked Yes or No for each item)

Yes	No	Medium
		In office <i>Photo Album</i> for prospective patients
		In office <i>Seminars</i> for prospective patients
		On Dr. Barone's <i>Website</i> for prospective patients
		In print Advertisements
		On <i>Television</i>
		Publication in <i>Books and Journals</i>

I further understand that:

1. These photographs, slides or videotapes may be published By Dr. Constance M. Barone and/or Constance M. Barone, M.D., F.A.C.S. in any print, visual, or electronic media including, but not limited to , medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of Dr. Constance M. Barone, for which Dr. Barone may receive direct or indirect remuneration.
2. I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the photographs, slides, or videotapes may display features that identify me.
3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to Constance M. Barone, M.D., F.A.C.S.; 2829 Babcock Road, suite 615; San Antonio, Texas 78229. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization.

Patient's Signature

Date

Dr. Barone's Signature

Date



Patient Photographic Authorization and Release (Continued)

- 4. I may refuse to sign this authorization without affecting the medical treatment I receive from Dr. Constance Barone.**
- 5. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).**
- 6. I release and discharge Dr. Constance Barone and/or Constance M. Barone, M.D., F.A.C.S. from all liability including liability for negligence, that in any way arises out of any and all rights that I may have or may have had in regards to the photographs, slides or videotapes of me including any claim for payment in connection with any publication of them in any medium. I release and hold harmless Dr. Constance M. Barone and Constance M. Barone, M.D., F.A.C.S., and her staff and her employees from any and all claims or causes of action that I may have of any nature whatsoever, which in any manner result from the use of the photographs or other images.**
- 7. This Authorization is made as a voluntary contribution in the interest of public education and I certify that I have read this Authorization and Release carefully and fully understand its terms and that Dr. Barone has answered all of my questions to my satisfaction.**

Patient's Signature

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Dr. Barone's Signature

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