New Patient Forms

Plastic & Reconstructive Surgery

Dr. Delio Ortegon, **MD, FACS**

SACS

SAN ANTONIO COSMETIC SURGERY, PA

BOARD CERTIFIED PLASTIC SURGEON

Patient Name: _____ ☐ **Female** ☐ **Male** ☐ **Female to Male** ☐ **Male to Female**

Age: _____ DOB: _____ SS#: _____

Address: _____
Street & Apt # City State Zip

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Marital status? ☐ Single ☐ Domestic Partner ☐ Married ☐ Divorced ☐ Widowed

Spouse Name: _____

Any restrictions for contacting you? ☐ Yes ☐ No **E-mail:** _____

Patient's Employer: _____ Occupation: _____

Address: _____
Street & Apt # City State Zip

Work Phone: _____ Ext: _____ Is it okay to contact you at work? Yes No

How did you hear about Dr. Ortegon? (Mark all that apply)

☐ Magazine ☐ Newsletter ☐ Seminar ☐ Salon ☐ Web ☐ Word of Mouth

☐ Friend/Relative: _____ ☐ Doctor: _____ ☐ Other: _____

If you were referred by a specific person, may we thank them? ☐ Yes ☐ No

Referral Name: _____ Contact Phone: _____

Date of Birth: _____ E-mail: _____

Emergency Contact: (Not in your household)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Other: _____

Authorization of Payment(s) :

I, the undersigned, understand that I am financially responsible for all charges in regards to my consultation and or treatments with San Antonio Cosmetic Surgery, PA, I, hereby authorize the release of all information necessary to secure payment.

Signature: _____ **Date:** _____

Allergies: ☐ **No Known Drug Allergies**

Do you have any Allergies to any medications? *(Please list including reactions)*

_____

Are you allergic to LATEX? ☐Yes ☐No Reaction: _____

Do you have any other Allergies (i.e. Shellfish, eggs, etc)? *(Please list including reactions)*

_____

Medications: Please list ALL medications and/or dietary supplements including:
(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)

☐ **Currently taking NO MEDICATIONS**

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

PHF REV 12/16

Review of Systems: ☐ **Currently None Apply**

General
- ☐ Fever/ Chills
- ☐ Unplanned weight-loss
- ☐ _____

Psychological
- ☐ Depression
- ☐ Anxiety

Skin
- ☐ Rashes

Abdomen
- ☐ Abdominal Pain
- ☐ Nausea / Vomiting
- ☐ Constipation
- ☐ Jaundice (Yellow skin)
- ☐ Diarrhea
- ☐ Black Stools
- ☐ Rectal Bleeding
- ☐ Acid
- ☐ Indigestion/Heartburn

Gynecological
- ☐ Irregular periods
- ☐ Pregnant
- ☐ Nipple Discharge

Breast
- ☐ Breast pain
- ☐ Breast lump
- ☐ Nipple discharge

Eyes/Ears/Nose/Throat
- ☐ Vision Problem
- ☐ Nose Bleeds
- ☐ Hearing Trouble
- ☐ Throat Discomfort
- ☐ Swollen lymph nodes

Heart
- ☐ Chest Pain/Pressure
- ☐ High Blood Pressure
- ☐ Heart Skipping/Irregular Heart beat
- ☐ Sudden fainting
- ☐ Swollen Feet or Ankles
- ☐ Shortness of breath lying down

Lungs
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Sputum (Phlegm)
- ☐ Wheezing
- ☐ Bloody Sputum (Bloody Phlegm)

Urinary
- ☐ Night time Urine
- ☐ Increased Urine
- ☐ Difficulty with Urine flow (poor flow)
- ☐ Blood in Urine
- ☐ Burning with Urination

Hematology (Blood)
- ☐ Easy bruising / bleeding
- ☐ Anemia
- ☐ Blood clots
- ☐ Low Iron Deficiency

Neurological
- ☐ Numbness
- ☐ Balance problems
- ☐ Dizziness

Endocrine (Hormones)
- ☐ Increased Thirst
- ☐ Heat Intolerance
- ☐ Dry skin
- ☐ Tremor
- ☐ Fatigue