675 North Saint Clair Street, Ste 19-250
Chicago, IL 60611-5964
312-695-6022
nm.org

REGISTRATION FORM FOR PLASTIC AND RECONSTRUCTIVE SURGERY

TODAY'S DATE _____/_____/_____

LEGAL NAME _____

PREFERRED NAME_____ PRONOUNS (optional) _____

DATE OF BIRTH _____/_____/_____ AGE_____

LEGAL SEX: MALE_____ FEMALE_____ GENDER IDENTITY (optional): _____

MARITAL STATUS: SINGLE _____ MARRIED _____ WIDOWED _____ DIVORCED _____

ADDRESS_____

CITY_____STATE_____ ZIP CODE_____

HOME #_____ WORK #_____ CELL #_____

E-MAIL_____

EMPLOYER_____

OCCUPATION_____

INSURANCE CARRIER_____

EMERGENCY CONTACT_____PHONE #_____

WHO REFERED YOU TO THIS OFFICE? _____

IS THIS PERSON AT NORTHWESTERN MEDICAL GROUP? YES _____ NO _____

IF NO, WHAT IS HIS/HER NAME, ADDRESS AND TELEPHONE #

_____

_____

WHO IS YOUR PRIMARY CARE PHYSICIAN _____

PRIMARY PHYSICIAN'S ADDRESS _____PHONE #_____

REASON FOR YOUR VISIT_____

TYPE OF INJURY: AUTO_____ WORKERS COMPENSATION_____ OTHER _____

WORKERS COMPENATATION CARRIER _____ PHONE # _____

Northwestern Medicine

PATIENT PREOPERATIVE HISTORY

LEGAL NAME _____ DATE OF BIRTH _____/_____/_____

PREFERRED NAME_____

PREFERRED DAYTIME PHONE # _____ PREFERRED LANGUAGE _____

PLANNED SURGERY_____

PRIMARY CARE PHYSICIAN_____ PCP PHONE # _____

PLEASE LIST ALL PREVIOUS SURGERIES (AND APPROXIMATE DATES)

PLEASE LIST ANY ALLERGIES TO MEDICATIONS, LATEX, FOOD OR OTHER (AND YOUR REACTIONS TO THEM)

LIST ALL MEDICATIONS (INCLUDE OVER-THE-COUNTER DRUGS, INHALERS, HERBAL SUPPLEMENTS AND ASPIRIN)

Drug Name	**Dosage**	**Frequency**	**Drug Name**	**Dosage**	**Frequency**

WEIGHT (LBS OR KG) _____ HEIGHT (INCHES OR CM) _____

PLEASE CHECK ANY THAT APPLY TO YOUR HEALTH:

- ☐ **Heart attack at any time**
- ☐ **Heart attack within the past 60 days**
- ☐ **Chest pain or pressure with activity**
- ☐ **Angina**
- ☐ **Heart failure**
- ☐ **Heart surgery**
- ☐ **Heart stent within the last 6 months**
- ☐ **Heart stent at any time**
- ☐ **Atrial fibrillation**
- ☐ **Arrhythmia**
- ☐ **Congenital heart disease**
- ☐ Hypertension
- ☐ **Murmur**
- ☐ **Valve disorder**
- ☐ **LVAD**
- ☐ **Heart device**
- ☐ **Pacemaker**
- ☐ **Defibrillator**
- ☐ **Fainted in the last year**
- ☐ Pain in legs while walking
- ☐ None of these

- ☐ **Unable to climb 2 flights of stairs or walking 2 blocks because of chest pain or trouble breathing**
- ☐ **Oxygen at home**
- ☐ **Pulmonary hypertension**
- ☐ **Asthma**
- ☐ **COPD**
- ☐ **Trouble breathing at rest or with minimal exertions**
- ☐ **Pneumonia in last 2 months**
- ☐ **Any problems with your lungs**
- ☐ **Severe cough**
- ☐ **None of these**

- ☐ Face, arm or leg weakness
- ☐ **Stroke/TIA within past 3 months**
- ☐ Stroke or TIA at any time
- ☐ Paralysis
- ☐ Difficulty speaking
- ☐ **Dementia**
- ☐ Parkinson's
- ☐ **Myasthenia gravis**
- ☐ **Muscular dystrophy**
- ☐ **Multiple sclerosis**
- ☐ **Spinal cord injury**
- ☐ **Brain tumor**
- ☐ **Brain aneurysm or AVM**
- ☐ **Epilepsy, blackouts or seizures**
- ☐ None of these

- ☐ **Hospitalized in last 30 days***
- ☐ Diabetes
- ☐ **Cancer: _____***
- ☐ **Chemo or radiation in last 3 months**
- ☐ **Kidney disease other than stones***
- ☐ **Liver disease**
- ☐ **Cirrhosis**
- ☐ **Lupus**
- ☐ Hepatitis B/C
- ☐ **Jaundice**
- ☐ **Hyperthyroidism**
- ☐ Hypothyroidism
- ☐ **Adrenal disorder**
- ☐ **Pituitary disorder**
- ☐ **Dialysis**
- ☐ **Scleroderma**
- ☐ **Rheumatoid arthritis**
- ☐ Sjogren's
- ☐ **HIV**
- ☐ **Use illegal drugs (excluding marijuana)**
- ☐ **Kidney failure**
- ☐ Taking antibiotics for any reason
- ☐ None of these

- ☐ **Blood thinners or anticoagulants other than aspirin**
- ☐ **Bleeding with surgery or tooth extractions**
- ☐ **Blood transfusion in last 3 months**
- ☐ **Blood clots/Pulmonary embolus**
- ☐ **Hemophilia**
- ☐ **Von Willebrands**
- ☐ **Known bleeding disorder**
- ☐ **Jehovah's Witness/Refusal blood products**
- ☐ **Sickle cell disease**
- ☐ **Anemia**
- ☐ Severe nose bleeds
- ☐ None of these

- ☐ Malignant hyperthermia (in blood relatives or self) with anesthesia
- ☐ Difficult airway during anesthesia
- ☐ **Severe nausea or vomiting from anesthesia**
- ☐ Dentures
- ☐ Problems opening your mouth
- ☐ Loose teeth
  None of these

- ☐ **Unintentional weight loss >10 lbs.**
- ☐ Difficulty getting out of bed/chair on your own
- ☐ Difficulty making your own meals
- ☐ Your physical abilities limit your daily activities
- ☐ Difficulty doing your own shopping
- ☐ Feel that everything you did was an effort: _____ days in the last week
- ☐ **Need assistance with eating, bathing or dressing**
- ☐ Fallen within the last 6 months: _____times
- ☐ None of these

- ☐ Very loud snoring
- ☐ Tired/fall asleep frequently during the day
- ☐ Observed to stop breathing during sleep
- ☐ High blood pressure/hypertension
- ☐ **Sleep apnea; NO CPAP**
- ☐ Sleep apnea; USES CPAP
- ☐ None of these
- ☐ Cannot speak and/or understand English
- ☐ Cannot lie flat for 45 minutes
- ☐ Currently pregnant. Last menstrual period: _____
- ☐ **Smoker (current or past) _____packs per day for _____years. Quit date_____**
- ☐ Drinks alcohol. How much each day? _____beers _____glasses of wine _____shots of hard alcohol

PLEASE LIST ANY MEDICAL ILLNESS OR MEDICATIONS NOT NOTED ALREADY:

_____

_____

BOLDED *items indicate the need for an in person preoperative evaluation*