ChevrayPlasticSurgery.com
6560 Fannin Street, Suite 2200
Houston, Texas 77030
(713) 441-0714

CHEVRAY Plastic Surgery
New Patient Information Form

Patient Name: _____ **Date:** _____

Age: _____ **Sex:** M_____ F_____ **Current Bra size:** _____

Height: _____ **Weight:** _____ **Ideal Bra size:** _____

HISTORY OF PRESENT ILLNESS

Who referred you to Dr. Chevray? _____

When did your condition first occur? _____

Describe your current condition: _____

_____

_____

_____

_____

Allergies (include reaction): _____

_____

Current Medications: _____

_____

_____

Medical Illnesses: _____

_____

_____

Previous surgeries: _____

_____

_____

_____

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CHEVRAY
PLASTIC SURGERY

Patient Name: _____

SOCIAL AND FAMILY HISTORY

Occupation: _____ **Marital Status:** _____

Spouse Occupation:_____ **Number and age of children:** _____

Family History (esp. cancer, stroke, heart attack): _____

_____

_____

Alcohol use (describe type and amount): _____

Circle one: Never Occasionally Daily Weekly

Tobacco use (describe type and amount): _____

Circle one: Never Occasionally Daily Weekly

Exercise use (describe type and amount): _____

Circle one: Never Occasionally Daily Weekly

Special diet (describe type and amount): _____

Circle one: Never Occasionally Daily Weekly

Please indicate any history or problems with the following:

	Yes	No		Yes	No
Chest pain			Weight gain/loss		
Heart Palpitations			Fevers		
Shortness of breath			Seizures		
Cough			Nausea/Vomiting		
High blood pressure			Heartburn		
Diabetes			Constipation		
Blood clots			Abdominal pain		
Thyroid disorder			Urinary symptoms		
Bleeding disorder			Hepatitis		
Anemia			Depression		
Stroke			Anxiety		
Fainting/Dizziness			Implants		

Comments: _____

HOUSTON Methodist LEADING MEDICINE

Weill Cornell Medical College