Richard A. Mouchantat, M.D., FACS
Mouchantat Plastic Surgery, P.C.
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Phone: 303-232-8585 eFax: 720-772-5770
Email: frontoffice@drmouchantat.com

NAME: _____
Height: _____ **Weight:** _____

REASON FOR VISIT: _____

MEDICAL/SURGICAL HISTORY

Nerve Problems	Yes / No	**Seizures**	Yes / No
Heart Problems	Yes / No	**High Blood Pressure**	Yes / No
Respiratory/Lung Problems	Yes / No	**Kidney/Bladder Issues**	Yes / No
Covid-19 Vaccination	Yes / No	**Bleeding Problems**	Yes / No
Thyroid disease	Yes / No	**Hepatitis/HIV/Liver Problems**	Yes / No
Arthritis/Osteoporosis	Yes / No	**Stomach/Digestion issues**	Yes / No
Vascular Problems	Yes / No	**Diabetes**	Yes / No

Tobacco use: Smoke / Chew / Vape / None **If past smoker when did you quit?** _____
Alcohol: Yes / No **How much?** _____ **How often?** _____
Marijuana/ Marijuana products: Yes / No **Recreational Drugs:** Yes / No

Past and Current Medical Problems: _____
_____
_____
_____
_____
Number of Pregnancies_____ **Number of children**_____

Surgical History: _____
_____
_____
_____

Family History of Breast or other cancers: _____
_____
_____

Medications and dosage: _____
_____
_____
_____

Allergies: _____
_____

Initial_____

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NAME_____

Have you experienced any of the following in recent days or weeks?

Weight loss/gain	Yes / No	**Abdominal Pain**	Yes / No
Fatigue	Yes / No	**Nausea/vomiting**	Yes / No
Fever/chills	Yes / No	**Painful urination or problem**	Yes / No
Exposure to TB	Yes / No	**Constipation**	Yes / No
Exposure to HIV	Yes / No	**Heartburn/reflux**	Yes / No
Skin rashes	Yes / No	**Bleeding problems**	Yes / No
New or Changing mole	Yes / No	**Unusual bruising**	Yes / No
Itching	Yes / No	**Blood clots/DVT/PE**	Yes / No
Breast Lumps	Yes / No	**Family History of DVT/PE**	Yes / No
Breast Tenderness	Yes / No	**Muscular weakness**	Yes / No
Nipple discharge	Yes / No	**Joint pain**	Yes / No
Difficulty hearing	Yes / No	**Muscle Cramps**	Yes / No
Vision problems	Yes / No	**Loss of balance**	Yes / No
Nasal discharge	Yes / No	**Numbness or tingling**	Yes / No
Nose bleeds	Yes / No	**Tremor**	Yes / No
Difficulty swallowing	Yes / No	**Fainting**	Yes / No
Neck stiffness/pain	Yes / No	**Loss of coordination**	Yes / No
Chest pain	Yes / No	**Anxiety**	Yes / No
Shortness of breath	Yes / No	**Depression**	Yes / No
Cough	Yes / No	**Hallucinations**	Yes / No
Loss of appetite	Yes / No		

Additional comments: _____
_____
_____

I attest that the above information is accurate and complete.

Consent to evaluation: I, (or the patient), hereby consent for examination and consultation as necessary and appropriate for my condition or illness by Dr. Richard Mouchantat. I am authorized to sign for my self or the patient.

Signature: _____ Date: _____