DEROSACENTER
Plastic Surgery
BOSTON | PALM BEACH

Pt ID#_____ **Patient's Name** _____

Birthdate _____ **Age** _____ **Height** _____ **Weight**_____

Address _____

_____

Phone Number _____**Email** _____

Reason for Visit: _____

How did you hear about Dr. DeRosa? _____

Emergency Contact Name _____ **Relationship**_____

Phone Number _____

Primary Care Doctor _____

Pharmacy _____

Patient Medical History

□ Healthy No Past Medical History
□ Lungs/ Pulmonary
□ Heart/ Cardiovascular
□ Diabetes
□ Cancer
□ Blood/Hematology
□ Endocrine
□ Infectious Diseases
□ Currently Pregnant
□ Other

Patient- Specific Questions:

-Do you form a thick or raised scar from a cut or burn? Yes No

-Do you ever get cold sores? Yes No

Previous Surgeries with Dates: _____

_____

Continue on Back →

DEROSA FACIAL PLASTIC SURGERY, PC
91 NEWBURY ST., SUITE 300, BOSTON MA 02116
INFO@DRJAIMIEDEROSA.COM P 617 262 8000
WWW.DRJAIMIEDEROSA.COM F 617 262 8002

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Allergies _____

Latex Allergy? Yes No

Environmental Allergies? Yes No

Medications _____

_____

Do you smoke? _____ If yes, How many packs a day? _____When did you start/stop? _____

Occupation/ Hobbies: _____

Patient Family History:

□ No Contributing Family History
□ Abnormal Bleeding/ Clotting
□ Anesthesia Problems
□ Malignant Hyperthermia
□ Skin Cancer
□ Adopted
□ Nasal Breathing Difficulty
□ Other

Review of Systems- Please Review list and check box if you have an issue/concern

□ All Normal
□ Allergic/ Immunologic
□ Cardiovascular
□ Constitutional
□ Ear, Nose, Mouth, Throat
□ Eyes
□ Endocrine
□ Gastrointestinal
□ Genitourinary
□ Hematologic/ Lymphatic
□ Musculoskeletal
□ Neurological
□ Psychiatric
□ Respiratory
□ Skin

The above information is accurate and complete to the best of my knowledge. I will inform Dr. DeRosa if anything changes.

Signature_____ **Date** _____

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