DIBELLO
PLASTIC SURGERY

2361 HUNTINGDON PIKE, HUNTINGDON VALLEY PA 19006
215.947.4990 · FAX 215.947.7660
WWW.DRDIBELLO.COM

PRE-CONSULTATION INTAKE

NAME: _____ **Date of Birth:** _____ **Marital Status:** ___ **S** ___**M** ___ **D** ___ **W**

Age:_____ **Height:** _____ Weight:_____ **Current Bra Size:** _____ **#Pregnancies:** _____ **#Children:**_____

Address: _____ **City:**_____ **State:**_____ **Zip:** _____

Telephone: Home: _____ **Work** _____ **Cell**_____

E-Mail Address: _____ **Preferred method of contact:**_____

Referring/Primary Care Doctor: _____

How did you hear about Dr DiBello? _____

Reason for your consultation: _____

Questions/concerns you would like to discuss with Dr. DiBello:_____

_____

Date of last mammogram (if applicable):_____ **Result:**_____

Are you pregnant, possibly be pregnant, or taking birth control pills? _____ **Y** _____ **N** _____ **NA**

Do you presently smoke? ____ **Y** _____ **N** **If yes, how much**_____
Have you ever smoked? ____ **Y** _____ **N** **If yes, when did you quit?**_____

Medical History Do you have or have you had any of the following? (Circle yes or no)

Rheumatic Fever	Y	N	Heart Trouble	Y	N	Heart Murmurs	Y	N	Abnormal Scarring	Y	N
Heart Palpitations	Y	N	Irregular Heart Beat	Y	N	Chest Pains	Y	N	Bleeding Problems	Y	N
Shortness of Breath	Y	N	Swelling of Ankles	Y	N	High Blood Pressure	Y	N	Emotional Problems	Y	N
Diabetes	Y	N	Cancer	Y	N	Kidney Problems	Y	N	Psychiatric Problems	Y	N
Eye Diseases	Y	N	Hepatitis	Y	N	Thyroid Problems	Y	N	Blood Transfusions	Y	N
Asthma	Y	N	Anemia	Y	N	Blood Disorders	Y	N	Blood Clot History	Y	N

Trouble with dryness, soreness, burning, itching or excessive tearing of eyes? ___**Y** ____ **N** **Seasonal allergies?** ____**Y** _____**N**

If you answered yes to any of the above, please explain: _____
_____

Previous surgery (list type/s and date/s): _____
_____
_____

Previous post-op complications: ❑ **No** ❑ **Yes** **If yes explain:** _____
Previous anesthesia problems: ❑ **No** ❑ **Yes** **If yes explain:** _____

Previous surgical or non-surgical treatments to area[s] of concern: _____

Allergies: Are you allergic to or have you ever had an allergic reaction to any medication, drug or local anesthetic? ____**Y** ____**N**

If yes, please list medication & reaction: _____

Medications: List any medications you are taking on a regular basis (include aspirin, herbal supplements, vitamins, etc.)

_____
_____
_____

Family Medical History (father, mother, grandparents, siblings, children): _____
_____

_____ _____
PATIENT SIGNATURE **DATE**