CHRISTOPHER J. DAVIDSON, M.D.
Plastic and Reconstructive Surgery

ASSISTANT PROFESSOR OF SURGERY
TUFTS UNIVERSITY SCHOOL OF MEDICINE

PATIENT INFORMATION

Patient Name _____ SSN _____
Date of Birth _____ Age _____ Marital status _____
Home Address _____ Home Phone _____
City, State, Zip _____ Cell Phone _____
Occupation _____ Employer _____
Email address _____

Primary care Physician _____ PCP's Phone _____
PCP's address _____ City, State, Zip _____

Who referred you to our practice? _____

EMERGENCY CONTACT

Name _____ Relationship _____
Home Phone _____ Work Phone _____
Cell Phone _____

INSURANCE INFORMATION

Insurance company name _____ Group # _____
ID# _____ Phone # _____
Street Address _____ City, State, Zip _____

SUBSCRIBER'S INFORMATION

Name _____ SSN _____
Date of Birth _____ Home Phone _____
Street address _____ Work Phone _____
City, State, Zip _____ Employer _____
Relationship to patient _____

I request that payment of authorized insurance benefits be made to Dr. Davidson for any services furnished to me by that physician or supplier. I authorize the release of medical information about me to my insurance company and its agents to determine the benefits or the benefits payable for related services. I understand my insurance policy, including any co-payments and/or deductibles, are my responsibilities. I permit a copy of this authorization to be used in place of the original.

Signature _____ Date _____

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MEDICAL AND SURGICAL HISTORY

Patient Name_____ SSN _____

Reason for today's visit _____

Do you smoke? ☐ No ☐ Yes, how much _____? If former smoker, date quit _____

Do you drink alcohol? ☐ No ☐ Yes, how much _____?

Please list any medications that you are taking, (and their doses) including non-prescription drugs, vitamins, and herbals._

_____

_____

Please list any allergies that you may have _____

Medical history _____

_____

Previous Surgery (and dates) _____

_____

Height _____ Weight _____

FAMILY HISTORY

Has any blood relative ever had the following?

Breast cancer… no yes
Melanoma……. no yes
High blood pressure…..no yes
Heart disease…….no yes
Kidney disease…..no yes
Stroke……....no yes

REVIEW OF SYSTEMS

Have you ever had the following?

Heart attack (MI)……...no yes
High blood pressure……..no yes
Elevated cholesterol……...no yes
Atrial Fibrillation.…….…….no yes
Emphysema/COPD……no yes
Shortness of breath……....no yes
Chest Pain……. no yes
Congestive Heart Failure...no yes
Depression…….no yes
Eating Disorder……..no yes
Panic Disorder……no yes
Anxiety……..no yes
Kidney Infection…….no yes
Hepatitis (A, B, or C)…….no yes
Cancer……no yes

Asthma……no yes
Pulmonary Embolus……no yes
Pneumonia……..no yes
Cataracts……no yes
Blindness……no yes
Glaucoma……no yes
Multiple Sclerosis……..no yes
CVA (Stroke)…….no yes
Seizure disorder……..no yes
Migraine…….no yes
Leg/ankle ulcers…….no yes
Blood clots…….no yes
Aneurysm……..no yes
Arthritis……..no yes
Fractures…….no yes

Keloid Scarring……no yes
Basal Cell / Squamous Cell……..no yes
Melanoma…….no yes
Peptic Ulcers/Reflux……no yes
Irritable bowel……..no yes
Liver disease……no yes
Diabetes……no yes
Hypothyroid…….no yes
Hyperthyroid……no yes
HIV (AIDS)……no yes
Sexually transmitted disease……no yes
Tuberculosis (TB)……no yes
Anemia…….no yes
Bleeding Disorders……..no yes
Anticoagulation Therapy…….no yes

Additional information you'd like us to know _____

_____

I verify that the above information is true and accurate to the best of my knowledge.

Signature _____ Date _____