Eugenie Brunner, M.D., P.A.
Woodlands Professional Building
256 Bunn Drive, Suite 4
Princeton, NJ 08540
Phone: (609) 921-9497 Fax: (609) 921-7040

Patient Information

Thank you for choosing our office. In order to serve you properly, we need the following information. Please print.

Patient Information

Patient Name: Last First Middle		**Date of Birth:**	**Age:**
Address:			
City:	**State:**	**Zip Code:**	
Social Security #:		**Check One: Male ð Female ð**	
Cell Phone:	**Home Phone:**	**Preferred Phone for Message:**	
Email Address:			
Check One: Minor ð Single ð Married ð Divorced ð Widowed ð Separated ð			

Patient's Employer:		**Occupation:**
Business Address:		**Work Phone:**
City:	**State:**	**Zip Code:**

Spouse's or Parent's Name:		**Home Phone:**
Home Address (if different from above):		
Employer:		**Occupation:**
Business Address:		**Work Phone:**
City:	**State:**	**Zip Code:**

Person to contact in case of Emergency:	**Phone:**
Relationship of Emergency Contact to Patient:	

Referring Physician:	**Phone:**
Family Physician:	**Phone:**

Insurance Information

Insured's Name:		**Relationship to Patient:**
Address:		**Home Phone:**
Social Security #:		**Date of Birth:**
Employer:		**Phone:**
Insurance Company:		**Phone:**
Insurance Company Address:		**Effective Date:**
Subscriber #:	**Policy #:**	**Group #:**

Payment is required at time of service unless prior arrangements have been made.
Please check preferred method of payment: **Cash ð Check ð Credit Card ð Debit Card ð**

Your acceptance below indicates your consent for treatment as patient.

I authorize release of any information concerning my (or my Child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits and to other physicians and legal professionals. I hereby authorize payment of insurance benefits otherwise payable to me directly to the physician. I understand that I am responsible for any amount not covered by insurance.

Signature:____ **Date:**_______________

Medical Questionnaire

Name: ________________________ **Date:** __________

What is the reason for your visit?

Are there any facial plastic procedures you wish to discuss?

OPERATIVE HISTORY

List ALL operative procedures including minor surgery, procedures done under local anesthesia and pregnancies:

Date(s) **Procedure(s)**

Have you ever had a blood transfusion?__________ **When?**__________
Date of last medical check-up__________ **Result:**__________
Date of last Chest X-ray__________ **Result:**__________
Date of last electrocardiogram (EKG)__________ **Result:**__________
Do you smoke? Yes No How much?__________ **How long?**__________
Do you drink alcohol? Yes No How much?__________ **How long?**__________
Do you use any recreational drugs? Yes No Which ones__________
Are you on a special diet? Yes No What kind?__________

How many children do you have?__________
List athletic activities__________
List hobbies__________

List ALL drug allergies or adverse reactions:__________

List environmental, contact and food allergies:__________

List ALL drugs and dosages (prescription, non-prescription, vitamins, health supplements)__________

Do you take aspirin (ASA) or ASA-containing medications, motrin/advil or ibuprofen-containing medications? Which ones__________

Are you under the care of a doctor for any other problems at this time?__________

Have you ever been dissatisfied with the treatment you received from a doctor or dentist?__________

Please check if any of the following apply to you:

	Yes
Radiation Therapy (eg. for acne, tonsils, or cancer)	[ ]
Accutane treatment for acne	[ ]
Skin, hair or nail diseases	[ ]
Facial operations	[ ]
Excessive sun exposure/sunburns	[ ]
Bleeding or bruising problems	[ ]
Eye problems, eyeglasses, or contacts	[ ]
Nose operations, Nose injuries	[ ]
Nose pain, bleeding, discharge	[ ]
Nose obstruction, snoring	[ ]
Nose allergies, polyps, loss of smell	[ ]
Sinusitis, post nasal drip	[ ]
Desire to change nasal shape	[ ]
Teeth, gum, mouth problems	[ ]
Dentures, Orthodontic appliances	[ ]
Noisy breathing, sleep problems, sleep apnea	[ ]
Shortness of breath, chest pain, angina	[ ]
Cough with blood or sputum	[ ]
Asthma, tuberculosis, bronchitis	[ ]
Marked weight ro appetite change	[ ]
Neck operations, masses, thyroid disease	[ ]
Trouble swallowing, hiatus hernia	[ ]
Ear pain, bleeding, discharge	[ ]
Ear operations, infections	[ ]
Hearing loss, use of hearing aids	[ ]
Ringing in ears, tinnitus	[ ]
Dizziness, vertigo	[ ]

Past Health And Family History

Check all medical conditions that you or your immediate family members (brothers, sisters, children, parents, grandparents) have now or have had in the past.

	Yourself	Family Members
Allergies, asthma, eczema, hay fever	[ ]	[ ]
Anesthesia reaction	[ ]	[ ]
Bleeding problem, anemia	[ ]	[ ]
Heart disease, heart murmurs	[ ]	[ ]
Heart attack, angina	[ ]	[ ]
Rheumatic fever	[ ]	[ ]
High or low blood pressure	[ ]	[ ]
High cholesterol, triglycerides	[ ]	[ ]
Stomach or ulcer disease	[ ]	[ ]
Liver, spleen disease, Jaundice or hepatitis	[ ]	[ ]
Kidney disease or stones, bladder disease	[ ]	[ ]
Venereal disease or genital disease	[ ]	[ ]
Gynecologic disorders (female)	[ ]	[ ]
HIV Risk, HIV positive, AIDS	[ ]	[ ]
Diabetes, thyroid, endocrine disorders	[ ]	[ ]
Blood, or lymph gland disorders	[ ]	[ ]
Cancer, breast cancer, skin cancer	[ ]	[ ]
Growths, cysts, tumors	[ ]	[ ]
Muscle, bone, or joint disorders	[ ]	[ ]
Nervous system disorders	[ ]	[ ]
Strokes, seizures	[ ]	[ ]
Migraines, Headaches	[ ]	[ ]
Psychological disorders	[ ]	[ ]
Alcohol or drug problems	[ ]	[ ]

Patient Signature:______________________________ **Physician Signature:**______________________________