MORGENSTERN CENTER
for Orbital and Facial Plastic Surgery
123 BLOOMINGDALE AVENUE, WAYNE, PA 19087-4056

Office: (610) 687-8771 Fax: (610) 687-8773 www.MorgensternCenter.com

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____ First _____ Middle _____ Last

Address _____ Street & Apt # _____ City _____ State _____ Zip

Home Phone _____ Cell Phone _____ Other Phone _____
Any restrictions for contacting you? ☐ No ☐ Yes E-mail _____

Age _____ Birthdate _____ SS# - - Gender _____

Marital Status ☐ Single ☐ Married to: _____ ☐ Other: _____

Patient's Employer Occupation

Work Phone _____ Ext: Is it okay to call you at work? ☐ Yes ☐ No

Address _____ Street & Suite # _____ City _____ State _____ Zip

How did you hear about Dr. Morgenstern?
(Mark all that apply)

☐ Phone Book ☐ Magazine ☐ Newsletter ☐ Seminar ☐ Web
☐ Friend/Relative: ☐ Doctor: ☐ Other:

If you were referred by a specific person, may we thank them? ☐ Yes ☐ No

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone

Yes **No**

Do we have your permission to discuss medical information with this person?

Signature _____ **Date** _____

The above information is accurate and complete to the best of my knowledge.

Signature _____ **Date** _____

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Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name: _____ Reason for Visit: _____

Age: _____ Height: _____ Feet _____ Inches Weight: _____ Lbs.

Primary Physician _____
Name Address

Cardiologist: _____
Name Address

List all Surgeries (Hospitalization and the Date of Occurrence):

List all Eye Surgeries with Date of Occurrence:

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Aids / HIV	No	Yes	Epilepsy / Seizures	No	Yes	Kidney Problems	No	Yes
Arthritis	No	Yes	Facial Pain	No	Yes	Pneumonia	No	Yes
Asthma	No	Yes	Fever Blisters	No	Yes	Sinus Infections	No	Yes
Bronchitis	No	Yes	Goiter / Thyroid	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Hay Fever/Allergies	No	Yes	Tonsillitis	No	Yes
Depression	No	Yes	Headaches/Migraine	No	Yes	Tuberculosis	No	Yes
Diabetics	No	Yes	Heart Trouble	No	Yes	Stomach Ulcers	No	Yes
Dizziness / Vertigo	No	Yes	Hepatitis	No	Yes	Chicken Pox/Shingles	No	Yes
Ear Infection	No	Yes	High Blood Pressure	No	Yes			

Do you smoke? No Yes If yes, how much? _____ Pack(s)/day How long? _____ Years

Do you drink alcohol? No Yes If yes, how much? _____ How often? _____

Do you use recreational drugs? No Yes If yes, describe: _____

Do you have bleeding or bruising problems? No Yes If yes, describe: _____

Do you have problems with scarring? No Yes If yes, describe: _____

Do you have any history of problems with anesthesia? No Yes If yes, describe: _____

List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency (***use add'l sheet if necessary***)

List ALL drug and/or latex ***allergies***.

The above information is accurate and complete to the best of my knowledge.

Signature _____ **Date** _____