



STEPHAN BAKER  
MD, MBA, FACS



PLASTIC SURGERY OF THE FACE, BREAST AND BODY  
CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY

MERRICK POINTE 3850 BIRD ROAD SUITE 702, MIAMI, FLORIDA 33146 - 305.381.8837 - drbaker.com

NEW PATIENT INFORMATION RECORD

Full Name \_\_\_\_\_ Date \_\_\_\_\_

Residence \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Cellular \_\_\_\_\_ E-Mail \_\_\_\_\_

Please contact me by: (INDICATE YOUR PREFERENCES) • Home • Work • Cellular • E-mail • SMS

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Social Security N° \_\_\_\_\_ Driver's License N° \_\_\_\_\_

Spouse / Closest Relative \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Person Financially Responsible \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Reason for Consultation \_\_\_\_\_

MEDICAL HISTORY

Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs. Maximum Weight \_\_\_\_\_ lbs. Minimum Weight \_\_\_\_\_ lbs

PREVIOUS SURGERIES

Procedure \_\_\_\_\_ Year \_\_\_\_\_ Complications \_\_\_\_\_

Procedure \_\_\_\_\_ Year \_\_\_\_\_ Complications \_\_\_\_\_

Were there any bleeding problems? \_\_\_\_\_

Any adverse reactions to local or general anesthesia? \_\_\_\_\_

List your allergies/sensitivities to medications: \_\_\_\_\_

List all current medications, vitamins or supplements: \_\_\_\_\_

SMOKING HISTORY If yes, how many years? \_\_\_\_\_ How much per day? \_\_\_\_\_

If you stopped, when? \_\_\_\_\_

MATERNAL HISTORY

Number of children, if any? \_\_\_\_\_ Currently pregnant? \_\_\_\_\_ Are you planning to have more children? \_\_\_\_\_

Please continue on Page 2



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**Have you ever had any of the following problems?** (IF YES, CIRCLE AND EXPLAIN BELOW)

- Easy Bruising, Unusual Bleeding, Bleeding Disorders, Anemia, Polycythemia, Lymphoma
- Breast Lumps, Breast Masses, Nipple Discharges
- Rashes, Skin Irritations, Skin Cancers
- Visual Disturbances, Dry Eyes, Unusual Tearing, Eye Infections, Cataracts
- Nasal Breathing Difficulties, Nasal Allergies, Nasal Polyps, Nasal Fractures
- Chest Pain (Angina), Shortness of Breath, Heart Attack, High Blood Pressure, Swollen Ankles
- Chronic Cough, Wheezing, Asthma, Emphysema, Pneumonia, Tuberculosis, Blood in Sputum
- Prolonged Indigestion, Heartburn, Ulcers, Gall Bladder Attacks, Jaundice, Change in Bowel Habits
- Pain/Difficulty Urinating, Kidney Stones/Infection, Bladder Infection
- Prolonged/Unusual Headaches, Numbness, Tingling, Seizures, Stroke, Loss of Consciousness
- Prolonged Depression, Manic-Depressive Disorder, Anxiety Disorder, Psychosis

**Have you ever been diagnosed with any of the following?** (IF YES, CIRCLE AND EXPLAIN BELOW)

- |                              |                               |                                |
|------------------------------|-------------------------------|--------------------------------|
| ▪ Breast Cancer              | ▪ Angina/Chest Pain           | ▪ Bone/Joint Disease           |
| ▪ Breast Cancer Family       | ▪ Heart Disease               | ▪ Lupus                        |
| ▪ Fibrocystic Breast Disease | ▪ High Blood Pressure         | ▪ Psychiatric Illness          |
| ▪ Hepatitis                  | ▪ Heart Attack                | ▪ Kidney Disease               |
| ▪ Ulcer Disease              | ▪ Rheumatic Heart Disease     | ▪ Bowel Abnormalities          |
| ▪ HIV Infection              | ▪ Claudication                | ▪ Hernia                       |
| ▪ Lung Disease               | ▪ Heart Valve Disorders       | ▪ Herpes                       |
| ▪ Asthma                     | ▪ Deep Vein Thrombosis        | ▪ Any Cancer                   |
| ▪ Pneumonia                  | ▪ Aneurysm                    | ▪ Any other Condition/Problem? |
| ▪ Thyroid Disease            | ▪ Stroke/TIA                  |                                |
| ▪ Diabetes                   | ▪ Varicose Veins              |                                |
| ▪ Adrenal Disease            | ▪ Peripheral Vascular Disease |                                |

**COMMENTS:**

**FULL SIGNATURE:** \_\_\_\_\_

**AUTHORIZATION** I hereby authorize Stephan Baker, M.D., F.A.C.S. to furnish information to insurance carriers when indicated. I hereby irrevocably assign all payments for rendered medical services to Stephan Baker, M.D., F.A.C.S. I understand that I am fully financially responsible for all charges, whether or not they are covered by insurance. If this account is assigned to an attorney for collection and/or suit, Stephan Baker, M.D., F.A.C.S. shall be entitled to reasonable attorney fees and costs of collection.

\_\_\_\_\_  
**RESPONSIBLE PARTY SIGNATURE**