

**Dr. Samieh Sam Rizk, M.D., F.A.C.S**  
**Manhattan Facial Plastic Surgery, P.L.L.C.**  
**Director**  
**1040 Park Avenue**  
**New York, N.Y. 10028**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M: \_\_\_ F: \_\_\_ Student? FT: \_\_\_ PT: \_\_\_  
Cell Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Marital Status: Married: \_\_\_ Single: \_\_\_ Widowed: \_\_\_ Divorced: \_\_\_  
Employer's Name: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_  
Social Security #: \_\_\_ - \_\_\_ - \_\_\_ Allergies To Medicine: \_\_\_\_\_  
Primary Care Doctor (first and last name): \_\_\_\_\_ Address: \_\_\_\_\_  
Referring physician: \_\_\_\_\_ Referral Phone #: \_\_\_\_\_  
Name of Dermatologist: \_\_\_\_\_ Phone#: \_\_\_\_\_

**Parent / Guardian / Spouse Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_ SS #: \_\_\_ - \_\_\_ - \_\_\_

**Primary Insurance**

Name of Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Date of Birth: \_\_\_\_\_ Insured's SS#: \_\_\_ - \_\_\_ - \_\_\_  
Employer's Name: \_\_\_\_\_

## Health Questionnaire

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

1. Have you suffered from?

Yes                  No

Heart Disease                  \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Heart Attack                  \_\_\_\_\_

Emphysema                  \_\_\_\_\_

Asthma                  \_\_\_\_\_

Blood Disease                  \_\_\_\_\_

Kidney Disease                  \_\_\_\_\_

Glaucoma                  \_\_\_\_\_

Diabetes                  \_\_\_\_\_

Jaundice/Hepatitis                  \_\_\_\_\_

Cancer                  \_\_\_\_\_

Anemia                  \_\_\_\_\_

Easy Bruising                  \_\_\_\_\_

Facial Trauma                  \_\_\_\_\_

Dry Eyes                  \_\_\_\_\_

Eating Disorder                  \_\_\_\_\_

Elaborate as needed: \_\_\_\_\_

2. Do you take?

St. John's Wort                  \_\_\_\_\_

Aspirin                  \_\_\_\_\_

Ginko                  \_\_\_\_\_

Vitamin E                  \_\_\_\_\_

3. Have you have ever taken?

Fen Fen                  \_\_\_\_\_

Accutaine                  \_\_\_\_\_

4. What medications do you use?

\_\_\_\_\_

\_\_\_\_\_

5. What medication are you allergic to?

\_\_\_\_\_

6. Do you have any other medical problems?

\_\_\_\_\_

7. Have you ever been hospitalized?

yes \_\_\_ no \_\_\_ please describe:

\_\_\_\_\_

\_\_\_\_\_

8. Have you ever had cosmetic surgery?

Yes \_\_\_ no \_\_\_ please describe:

\_\_\_\_\_

\_\_\_\_\_

9. Have you ever had any other surgery?

Yes \_\_\_ no \_\_\_ please describe:

\_\_\_\_\_

\_\_\_\_\_

10. Have you ever had any of the following habits? Yes \_\_\_ no \_\_\_

smoking

Frequency \_\_\_\_\_

Alcohol

Frequency \_\_\_\_\_

Recreational Drugs

Frequency \_\_\_\_\_

11. Do you have any caps, crowns, bridges, or loose teeth?

\_\_\_\_\_

\_\_\_\_\_

12. Are you currently undergoing dental work? \_\_\_\_\_

13. How did you hear of our office?

\_\_\_ Google \_\_\_ Ask.com

\_\_\_ Yahoo \_\_\_ Facebook

\_\_\_ AOL \_\_\_ Makemeheal.com

\_\_\_ Msn/Bing \_\_\_ Other Website

\_\_\_ Friend/Family \_\_\_ Physician

\_\_\_\_\_