UCLA He	alth	UCLA Division of Plastic & Reconstructive Surgery New Patient Packer	
Affix Pati	ent Label Here		
Name:		Date of Birth:	
Height: We	eight:	Left / Right Handed (please circle)	
Reason for Consultatio	n:		
Primary Care Physician	:		
Address:		Fax:	
	7:		
State:	Zip:		
Referred By:			
Name:		Phone:	
			
State:	Zip:		
Smoking History:	 Currently Quit less t per da Quit more packs 	 Never smoked Currently smoking packs per day Quit less than 2 months ago, previously smokedpacks per day Quit more than 2 months ago, previously smokedpacks per day Current using nicotine replacement therapy (patch, gum, etc.) 	
Alcohol Use:	🗖 Yes – amo 🗖 No	 Yes – amount per week: No 	
Living Situation:	AloneWith dependent	☐ With adults endents	
Marital Status:	SingleMarriedDivorced	 Domestic Partnership Separated Widowed 	
Number of Pregnancie	ς.	Number of Children	
Number of Pregnancies	s:	Number of Children:	