

PITTMAN PLASTIC SURGERY P.C.

Please fill out form completely - Do not leave any spaces blank - If it does not apply, please write in, "N/A"

Name: _____ Date: _____

Date of Birth: _____/_____/_____

Primary Care Physician: _____

Reason for today's visit: _____

Allergies (Any meds you cannot take?) _____

Date of injury/first symptom: _____/_____/_____

Is condition/injury work related? Yes No

List previous surgeries and dates if known: _____

Have you or any family member ever had complications related to anesthesia including high fever? _____

List all current medications (include aspirin, birth control, vitamins) _____

Height _____ Weight _____ Age _____

Past Medical History:

Have you ever had the following:

| | | | | | |
|----------------------------|-----|-------------------------------|-----|-----------------------------|-----|
| Anemia.....no | yes | Heart murmur.....no | yes | Poor circulation.....no | yes |
| Cancer.....no | yes | Irregular heart beat.....no | yes | Seizure.....no | yes |
| If Yes, type_____ | | Thyroid problems.....no | yes | Bowel/stomach disorders..no | yes |
| Diabetes.....no | yes | Hepatitis.....no | yes | Emphysema/COPD.....no | yes |
| High blood pressure.....no | yes | Keloids/excessive scaring..no | yes | Bronchitis.....no | yes |
| Kidney disease.....no | yes | Rheumatic fever.....no | yes | Cough >3 wks.....no | yes |
| Stroke.....no | yes | Ulcers.....no | yes | Prosthesis.....no | yes |
| Asthma.....no | yes | Arthritis.....no | yes | Jaundice.....no | yes |
| Heart disease.....no | yes | Excessive bleeding.....no | yes | Autoimmune Disease.....no | yes |
| | | | | Other_____ | |

Family History:

Has any blood relative had the following:

| | | | | | |
|----------------------------|-----|----------------------|-----|-----------------------|-----|
| High blood pressure.....no | yes | Heart disease.....no | yes | Kidney disease.....no | yes |
| Melanoma.....no | yes | Cancer.....no | yes | Stroke.....no | yes |
| Diabetes.....no | yes | If Yes, type_____ | | Other_____ | |

Reviews of Systems:

Do you have or have you had in the last year:

| | | | | | |
|-------------------------|-----|----------------------------|-----|-------------------------------|-----|
| Weight change.....no | yes | Swollen ankles/feet.....no | yes | Seizures.....no | yes |
| Dry eyes.....no | yes | Skin rash.....no | yes | Joint or muscle problems...no | yes |
| Chronic cough.....no | yes | Chronic diarrhea.....no | yes | Swollen lymph nodes.....no | yes |
| Chest pain.....no | yes | Jaundice.....no | yes | Easy bleeding.....no | yes |
| Rapid heart beat.....no | yes | Depression.....no | yes | Easy bruising.....no | yes |
| Sinus problems.....no | yes | Urinary problems.....no | yes | Other_____ | |

Do you smoke/use tobacco products? Yes No Packs/Day _____ Other _____

Do you drink alcohol? Yes No Drinks/Day _____

Is there any chance that you are pregnant? Yes No

I verify that the above information is true and accurate to the best of my knowledge.

X _____ Date _____
Signature of Patient/Responsible Party

(continued on back)

PITTMAN PLASTIC SURGERY P.C.

Patient Name: _____ Date: _____

Our goal is to respond to all your needs and concerns as a patient, and it is our pleasure to provide a wide range of cosmetic services in addition to our reconstructive procedures. Please check the areas you would like more information on.

What are your areas of concern? (Please check all that apply).

- | | | |
|--|--|--|
| <input type="checkbox"/> Breasts too small | <input type="checkbox"/> Facial Lines/Wrinkles | <input type="checkbox"/> Botox |
| <input type="checkbox"/> Breasts too large | <input type="checkbox"/> Drooping Eyes | <input type="checkbox"/> Facial Fillers (Juvederm Restylane) |
| <input type="checkbox"/> Sagging Breasts | <input type="checkbox"/> Puffy Eyes | <input type="checkbox"/> Skin Care Products/Advice |
| <input type="checkbox"/> Abdominal Area | <input type="checkbox"/> Neck | <input type="checkbox"/> Chemical Peels |
| <input type="checkbox"/> Hip/Thigh Area | <input type="checkbox"/> Thin Lips | <input type="checkbox"/> Longer Fuller Lashes |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Arms | <input type="checkbox"/> Payment Plans |
| | | <input type="checkbox"/> _____ |

Additional Comments: _____
