PITTMAN PLASTIC SURGERY P.C.

Please fill out form completely.

Name ____ Date: ____________

Date of birth: ______ / ______ / ______

Primary Care physician: ____________________ Referring physician: ____________________

Reason for today's visit: ____

ALLERGIES ____

MEDICATIONS List **ALL** current medications (including aspirin, birth control, vitamins) ____________________

____

Pharmacy: ____________________ Location: ____________________ Phone: ____________________

Date of injury / first symptom: ______ / ______ / ______ Is your condition or injury work related? ❑ yes ❑ no

List **ALL** previous surgeries and dates: ____

____

____

Have you or any family member ever had complications related to anesthesia including high fever? ❑ yes ❑ no

Height __________ Weight __________ Age __________

Past Medical History:

Anemia	❑ yes	❑ no	DVT or Pulmonary Embolus	❑ yes	❑ no	Liver Disease	❑ yes	❑ no
Arthritis	❑ yes	❑ no	Excessive Bleeding	❑ yes	❑ no	MRSA	❑ yes	❑ no
Asthma	❑ yes	❑ no	Glaucoma	❑ yes	❑ no	Multiple Miscarriages	❑ yes	❑ no
Autoimmune Disease	❑ yes	❑ no	Heart Disease	❑ yes	❑ no	Poor Circulation	❑ yes	❑ no
Blood Clots	❑ yes	❑ no	Heart Murmur	❑ yes	❑ no	Prosthesis	❑ yes	❑ no
Bowel / Stomach Disorders	❑ yes	❑ no	Hepatitis	❑ yes	❑ no	Rheumatic Fever	❑ yes	❑ no
Bronchitis	❑ yes	❑ no	High Blood Pressure	❑ yes	❑ no	Seizure	❑ yes	❑ no
Cancer	❑ yes	❑ no	HIV/AIDS	❑ yes	❑ no	Stroke	❑ yes	❑ no
If yes, type:			Irregular Heartbeat	❑ yes	❑ no	Thyroid Problems	❑ yes	❑ no
Cough > 3 weeks	❑ yes	❑ no	Jaundice	❑ yes	❑ no	Ulcers	❑ yes	❑ no
Diabetes	❑ yes	❑ no	Keloids / Excessive Scarring	❑ yes	❑ no	Other:	❑ yes	❑ no
Dry Eyes	❑ yes	❑ no	Kidney Disease	❑ yes	❑ no			

Review of Symptoms: (DO YOU HAVE OR HAVE YOU HAD IN THE LAST YEAR)

Chest Pain	❑ yes	❑ no	Jaundice	❑ yes	❑ no	Swollen Ankles / Feet	❑ yes	❑ no
Chronic Cough	❑ yes	❑ no	Joint or Muscle Problems	❑ yes	❑ no	Swollen Lymph Nodes	❑ yes	❑ no
Chronic Diarrhea	❑ yes	❑ no	Rapid Heartbeat	❑ yes	❑ no	Urinary Problems	❑ yes	❑ no
Depression	❑ yes	❑ no	Seizures	❑ yes	❑ no	Weight Change	❑ yes	❑ no
Dry Eyes	❑ yes	❑ no	Shortness of Breath	❑ yes	❑ no	Other:	❑ yes	❑ no
Easy Bleeding	❑ yes	❑ no	Sinus Problems	❑ yes	❑ no			
Easy Bruising	❑ yes	❑ no	Skin Rash	❑ yes	❑ no			

Family History: (HAS ANY BLOOD RELATIVE HAD THE FOLLOWING)

Cancer	❑ yes	❑ no	Heart Disease	❑ yes	❑ no	Stroke	❑ yes	❑ no
If yes, type:			High Blood Pressure	❑ yes	❑ no	Blood Clots	❑ yes	❑ no
Diabetes	❑ yes	❑ no	Kidney Disease	❑ yes	❑ no	DVT or Pulmonary Embolus	❑ yes	❑ no
Glaucoma	❑ yes	❑ no	Melanoma	❑ yes	❑ no	Other:		

Do you use nicotine products (i.e. cigarettes, cigars, e-cigarettes, gums, patches, vaporizers)? ❑ yes ❑ no

packs/day ______ other ______

Do you drink alcohol? ❑ yes ❑ no Amount ________ per day/week

Is there a 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.

Name____ Date:______________

Our goal is to respond to all your needs and concerns as a patient.
It is our pleasure to provide a wide range of services.

PLEASE CHECK ALL YOUR AREAS OF CONCERN:

- ❑ Abdominal area
- ❑ Breasts: too small
- ❑ Breasts: too large
- ❑ Sagging Breasts
- ❑ Breast Reconstruction
- ❑ Arms
- ❑ Thighs / Buttock
- ❑ Puffy Eyes
- ❑ Drooping / Tired Eyes
- ❑ Facial Lines / Wrinkles
- ❑ Thinning Lips
- ❑ Neck
- ❑ Nose
- ❑ Acne
- ❑ Skin Texture / Tone
- ❑ Sunspots
- ❑ Thinning Lashes
- ❑ Payment Plans
- ❑ Other: ______________________

Additional comments: ____

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