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, OVER THE COUNTER)** _____

_____

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:

Accutane (current or within 6 months)	❑ yes	❑ no	Connective tissue disorders (cutis laxa, Ehler's Danlos syndrome)	❑ yes	❑ no	Jaundice	❑ yes	❑ no
Anemia	❑ yes	❑ no	Cough > 3 weeks	❑ yes	❑ no	Keloids / excessive scarring	❑ yes	❑ no
Arthritis	❑ yes	❑ no	Dementia	❑ yes	❑ no	Kidney disease	❑ yes	❑ no
Asthma	❑ yes	❑ no	Diabetes	❑ yes	❑ no	Emphysema / COPD	❑ yes	❑ no
Autoimmune disease	❑ yes	❑ no	DVT or Pulmonary Embolus	❑ yes	❑ no	Multiple Miscarriages	❑ yes	❑ no
Bell's Palsy	❑ yes	❑ no	Excessive bleeding	❑ yes	❑ no	MRSA	❑ yes	❑ no
Blood Clots	❑ yes	❑ no	Glaucoma	❑ yes	❑ no	Poor circulation	❑ yes	❑ no
Blood clotting disorders (factor V leiden, von williebrand's)	❑ yes	❑ no	Heart disease	❑ yes	❑ no	Prosthesis	❑ yes	❑ no
			Heart murmur			Rheumatic fever	❑ yes	❑ no
Bowel / stomach disorders	❑ yes	❑ no	Hepatitis	❑ yes	❑ no	Seizure	❑ yes	❑ no
Bronchitis	❑ yes	❑ no	High blood pressure	❑ yes	❑ no	Stroke	❑ yes	❑ no
Cancer If yes, type:	❑ yes	❑ no	HIV/AIDS	❑ yes	❑ no	Thyroid problems	❑ yes	❑ no
			Irregular Heartbeat			Ulcers	❑ yes	❑ no
						Other:		

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

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

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

Cancer If yes, type:	❑ yes	❑ no	Heart disease	❑ yes	❑ no	Stroke	❑ yes	❑ no
			High blood pressure	❑ yes	❑ no	DVT or Pulmonary Embolus	❑ yes	❑ no
Diabetes	❑ yes	❑ no	Kidney disease	❑ yes	❑ no	Other:		
Glaucoma	❑ yes	❑ no	Melanoma	❑ yes	❑ no			

Do you use nicotine products (i.e. cigarettes, tobacco, gums, patches, vape)? ❑ yes ❑ no packs/day _____ other _____

Are you exposed to second hand smoke? ❑ yes ❑ no Do you vape? ❑ yes ❑ no

Do you drink alcohol? ❑ yes ❑ no

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
- ❑ Cellulite
- ❑ Sunspots
- ❑ Thinning Lashes
- ❑ Payment Plans
- ❑ Other: _____

Additional comments: _____