

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

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

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

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

Blood Clotting Disorder	<input type="checkbox"/> yes <input type="checkbox"/> no	DVT or Pulmonary Embolus	<input type="checkbox"/> yes <input type="checkbox"/> no	Kidney disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	Glaucoma	<input type="checkbox"/> yes <input type="checkbox"/> no	Melanoma	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes, type:		Heart disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Stroke	<input type="checkbox"/> yes <input type="checkbox"/> no
Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	High blood pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	Other:	

Do you use nicotine in any form (i.e. cigarettes, tobacco, gums, patches, spray)? ☐ 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

Have you had any vein treatments in the past

Is there a chance that you are pregnant? ☐ yes ☐ no

6 months? ☐ yes ☐ no

I verify that the above information is true and accurate.

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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Abdominal area | <input type="checkbox"/> Drooping / Tired Eyes | <input type="checkbox"/> Sunspots |
| <input type="checkbox"/> Breasts: too small | <input type="checkbox"/> Facial Lines / Wrinkles | <input type="checkbox"/> Thinning Lashes |
| <input type="checkbox"/> Breasts: too large | <input type="checkbox"/> Thinning Lips | <input type="checkbox"/> Payment Plans |
| <input type="checkbox"/> Sagging Breasts | <input type="checkbox"/> Neck | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Breast Reconstruction | <input type="checkbox"/> Nose | |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Acne | |
| <input type="checkbox"/> Thighs / Buttock | <input type="checkbox"/> Skin Texture / Tone | |
| <input type="checkbox"/> Puffy Eyes | <input type="checkbox"/> Cellulite | |

Additional comments: _____

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.