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:

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

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

Symptom	yes	no	Symptom	yes	no	Symptom	yes	no
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)

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

Do you use nicotine in **ANY** form (i.e. cigarettes, tobacco, gums, patches, spray, etc.)? ❑ 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 6 months? ❑ yes ❑ no

Is there a chance that you are pregnant? ❑ 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:

- ❑ 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: ____________________________________

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