# Pope Plastic Surgery

## Patient Information

Patient Name: _____
Last First Middle

Date of birth _____ Age _____ Sex_____

Street address _____ City_____ State _____ Zip _____

Mailing address _____ City_____ State _____ Zip _____

Contact number: _____ ❑ Cell ❑ Work ❑ Landline

E-mail address_____

Occupation: _____Employer_____

❑ Check if you would NOT like to receive promotional information from us

## Parent or Spouse Information

Name _____Relationship_____

Contact number: _____ ❑ Cell ❑ Work ❑ Landline

## Referral information

What is the reason for today's visit? _____

Have you been treated elsewhere for this? ❑ No ❑ Yes If so, by whom? _____

Name/Address of Primary Care Physician _____

_____

Referred by_____Address_____

Phone_____ May we thank them for referring you? ❑ Yes ❑ No

Did you hear about us in any of the following media? ❑ Magazine (which one?) _____

❑ Word of mouth ❑ Internet Search Engine ❑ College Park Newspaper

❑ My doctor_____ ❑ Other _____

## Emergency Contact

Name _____ Relationship to you_____

Contact number_____ ❑ Cell ❑ Work ❑ Landline

Street address _____ City_____ State _____ Zip _____

# Pope Plastic Surgery

## Medical History

Name _____ Date of Birth _____

Please check all that apply and explain:

- ❑ Abdominal Bleeding _____
- ❑ Asthma _____
- ❑ Breast Cancer _____
- ❑ Cancer _____
- ❑ Chest Pain _____
- ❑ Chemo/Radiation Therapy _____
- ❑ Diabetes _____
- ❑ Heart Disease _____
- ❑ Heart Murmur _____
- ❑ Hepatitis or yellow jaundice _____
- ❑ High Blood Pressure _____
- ❑ HIV _____
- ❑ Kidney Problems _____
- ❑ Skin Cancer _____
- ❑ Stroke _____
- ❑ Thyroid disorder _____
- ❑ Tuberculosis _____
- ❑ Eye Trouble _____
- ❑ Blood Clots/Bleeding Disorders
- ❑ MRSA _____
- ❑ Neurological Disease _____
- ❑ Malignant Hyperthermia _____
- ❑ Psychiatric Conditions (Anxiety/Depression, etc.) _____
- ❑ Other: relevant conditions: _____
- ❑ No relevant conditions _____

## Surgeries/Hospitalization History

| Surgery/Hospitalization | Year | Anesthesia Complications |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## Family Medical History

Affected family members:

- ❑ Breast Cancer _____
- ❑ Cancer _____
- ❑ Diabetes _____
- ❑ Heart Disease _____
- ❑ High Blood Pressure _____
- ❑ Blood Clots/Bleeding Disorders _____
- ❑ Obesity _____
- ❑ BRCA Positive _____
- ❑ Other relevant conditions: _____
- ❑ Unknown/Adopted

## Smoking Status

- ❑ Current every day smoker Number of cigarettes per day? _____
- ❑ Current some days smoker Number of smoking days per week?_____ Number of cigarettes per week?_____
- ❑ Former smoker Stopped: _____
- ❑ Never smoked ❑ E-cigarettes

## Type of Nicotine

❑ Cigarettes ❑ E-cigarettes ❑ Vaping ❑ Oral/Chewing

## Height/Weight

Height: _____ Weight: _____

## Alcohol

❑ No ❑ Yes Daily amount?_____ ❑ Socially Explain_____

## Recreational Drugs

- ❑ No
- ❑ Yes Type_____ Amount_____

## Allergies

Comments/Reactions

- ❑ No known allergies
- ❑ Medications _____
- ❑ Food _____

## Pharmacy

Name _____ Phone _____

Address _____

## Medications

(Please include prescriptions, over-the-counter, supplements and vitamins)

❑ None

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

## Communication Use & Disclosure Authorization

You may leave a voicemail or send an email regarding:

❑ Appointment information
❑ Alle
❑ Prescriptions/refills
❑ Rererral information
❑ Test results
❑ Other

You may discuss information and care with the following family members or friends:

_____

_____

_____

## Acknowledgement of Receipt of Privacy Practices

I or my legally authorized representative was offered and/or received a copy of Pope Plastic Surgery's Notice of Privacy Practices.

Patient's Signature:_____ Date_____

Agent's Signature: _____ Date_____

**All of the information provided is accurate and complete to the best of my knowledge:**

_____ _____

Print Name Patient or guardian signature

Submit