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plastic surgery

PATIENT HEALTH HISTORY

Patient Name: _____ **DOB**: _____ **Age**: _____

Height: _____ **Weight**: _____ **Primary Care Doctor:** _____

Current Medical Problems / Illnesses:

_____

List Previous Surgeries (including cosmetic surgery):

_____

_____

_____

List All Medications including vitamins, supplements, herbal medicines:

_____

_____

List any Medication Allergies, Food & Environmental Allergies:

_____

_____

Past Medical History:

Heart Disease	☐ Yes ☐ No	HIV or AIDS	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Lung Disease	☐ Yes ☐ No	Joint Replacement	☐ Yes ☐ No	Bleeding Tendency	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Skin Cancer	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Stomach Problems	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Breast Cancer	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Skin Cancer	☐ Yes ☐ No
Kidney Diease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
Blood Clot in Legs	☐ Yes ☐ No	Other Cancer	☐ Yes ☐ No	If so, what kind?	

Family History:

Have any of your relatives had any of the following? (Please check the appropriate answer)

Breast Cancer	☐ Yes ☐ No	If yes, relationship: _____
Skin Cancer	☐ Yes ☐ No	If yes, relationship: _____

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Diabetes	☐ Yes ☐ No	If yes, relationship: _____
Heart Disease	☐ Yes ☐ No	If yes, relationship: _____
Kidney Disease	☐ Yes ☐ No	If yes, relationship: _____
Stroke	☐ Yes ☐ No	If yes, relationship: _____
Depression	☐ Yes ☐ No	If yes, relationship: _____
High Blood Pressure	☐ Yes ☐ No	If yes, relationship: _____

Any issues with Anesthesia in the past? ☐ Yes ☐ No

If so, please describe: _____

Social History:

Do you currently smoke cigarettes? ☐ Yes ☐ No If so, how many packs per day? _____

Did you smoke before? ☐ Yes ☐ No If so, when did you quit? _____

Do you currently smoke marijuana? ☐ Yes ☐ No If so, how often? _____

Alcohol use? ☐ Yes ☐ No How many alcoholic drinks per week? _____

Recreational Drug Use? ☐ Yes ☐ No If so, what kind? _____

Review of Systems:

Have you had any of the below listed symptoms in the past year?

Fever & Chills	☐ Yes ☐ No	Swollen Feet	☐ Yes ☐ No	Swollen Lymph Nodes	☐ Yes ☐ No
Skin Lesions/Rash	☐ Yes ☐ No	Body Piercing	☐ Yes ☐ No	Joint Pain	☐ Yes ☐ No
Headache	☐ Yes ☐ No	Weight Change	☐ Yes ☐ No	Muscle Pain	☐ Yes ☐ No
Dry Eyes	☐ Yes ☐ No	Abdominal Pain	☐ Yes ☐ No	Dentures	☐ Yes ☐ No
Ear Infection	☐ Yes ☐ No	Chronic Cough	☐ Yes ☐ No	Wear Contacts	☐ Yes ☐ No
Sinusitis	☐ Yes ☐ No	Chest Pain	☐ Yes ☐ No	Easy Bruising	☐ Yes ☐ No
Wheezing	☐ Yes ☐ No	Sore Throat	☐ Yes ☐ No	Easy Bleeding	☐ Yes ☐ No
Urinary Infection	☐ Yes ☐ No	Taken Steroids	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Seizures	☐ Yes ☐ No	Tattoos	☐ Yes ☐ No
Jaundice	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No	Breast Lump	☐ Yes ☐ No

Women Only:

Number of pregnancies: _____ Date of last menstrual period: _____

Number of children: _____ Date of last mammogram? _____ Results: _____

Did you breast feed? ☐ Yes ☐ No

Do you perform regular self-examinations on your breasts? ☐ Yes ☐ No

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PATIENT REGISTRATION

Patient Name: _____ DOB: _____ Sex: ☐ Female ☐ Male

Street Address: _____ City:_____ State: ____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Occupation: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

Reason for today's visit: _____

How did you hear about us? Please choose all that apply. **Thank you!**

☐ I am a returning patient

☐ Referred by another patient Name: _____

☐ Referred by a doctor or medical professional Name: _____

☐ Referred by friend/family (not a patient) Name: _____

☐ Dr. Roth's Website ☐ Instagram ☐ Facebook ☐ American Society of Plastic Surgeons (ASPS)

☐ Dr. Roth's Podcast ☐ Word of Mouth ☐ Google ☐ Other _____

By signing below:

I consent for treatment / examination by Dr. Roth and/or his staff.

I consent to contact by phone, text and/or email for appointment reminders and/or marketing & practice news.

Signature:_____ Date: _____

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MEDICAL WEIGHT LOSS MANAGEMENT PROGRAM INTAKE FORM

What is your purpose for the medical weight loss injection program?

_____

What is the reason you want to lose weight?

_____

How long has your weight been a problem?

_____

Are you currently at your heaviest weight? If not, how much did you weigh at your heaviest?

_____

What is your worst food / drink, etc. habit?

_____

_____

Are you a stress eater? ☐ Yes ☐ No

Do you eat late in the night? ☐ Yes ☐ No

Does your significant other struggle with weight issues? ☐ Yes ☐ No

What methods have you previously tried to lose weight?

_____

_____

Are you scared of needles/needle phobic/ faint easily when you have blood taken?
☐ Yes ☐ No

Are you trying for pregnancy or planning pregnancy in the near future? ☐ Yes ☐ No

Are you or could you be pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Are you on any type of hormone replacement therapy? ☐ Yes ☐ No

Are you on any contraceptive methods? ☐ Yes ☐ No

Patient Name: _____ Patient Signature: _____

Date: _____

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MEDICAL WEIGHT LOSS FORM - PAST OR CURRENT MEDICAL HISTORY

Please check the box next to questions to which you answer *yes* (leave the others blank)

- ☐ Heart disease (such as heart attack, rheumatic fever, irregular heartbeat, angina, heart murmur, chest pain)
- ☐ Diseases of the arteries
- ☐ High blood cholesterol
- ☐ Anemia or other blood disorders i.e. Sickle Cell disease, Thalassemia
- ☐ History of dizziness, seizures or stroke
- ☐ Medullary thyroid cancer
- ☐ Any thyroid disease / problem
- ☐ Parathyroid problems or Adrenal gland problems
- ☐ Diabetes or abnormal blood-sugar tests
- ☐ Phlebitis (Inflammation of a vein)
- ☐ Deep vein thrombosis / blood clot in the leg (DVT) or PE (pulmonary embolism)
- ☐ Gallstones or any gallbladder disease (including jaundice)
- ☐ High blood pressure
- ☐ (Hypertension) Severe reflux
- ☐ Any breathing problems (such as asthma, COPD, bronchitis
- ☐ Infection endocarditis
- ☐ Kidney problems including chronic kidney disease (CKD)
- ☐ Pancreas / digestion problems (including acute or chronic pancreatitis)
- ☐ Stomach / duodenum / gastric ulcer
- ☐ Liver problems (including hepatitis, liver failure, fatty liver, alcoholic liver disease)
- ☐ Any neurological problems (including Parkinson’s Disease
- ☐ Severe stomach/gut problems (including inflammatory bowel disease, Crohn’s disease or Ulcerative colitis)
- ☐ Irritable bowel syndrome (IBS)
- ☐ Skin conditions
- ☐ Eating disorders (such as anorexia or bulimia)
- ☐ Mental health problems (including personality disorder, psychosis, diagnosis of depression)
- ☐ Self-diagnosis of depression, low mood, nervous or emotional problems

☐ Substance abuse (including alcohol or drugs)

☐ Any allergies (including food or drugs)

☐ Do any of the contraindications discussed apply to you?

MEDICAL WEIGHT LOSS - FAMILY HISTORY

Please check the box next to questions to which you answer ***yes*** (leave the others blank)

☐ Heart attacks under age 50

☐ Strokes under age 50

☐ High blood pressure

☐ Elevated blood pressure

☐ Elevated cholesterol

☐ Diabetes

☐ Asthma or hay fever

☐ Skin allergies

☐ Congenital heart disease (existing at birth but not hereditary)

☐ Heart operations

☐ Red blood cell disorders i.e. Sickle Cell, Thalassemia and Anemia

☐ Glaucoma

☐ Kidney Disease

☐ Obesity (20 or more pounds overweight)

☐ Leukemia or cancer under age 60

Patient Signature: _____ Date: _____

Print Patient Name: _____

Practitioner Name: _____ Date: _____