# *Welcome to* GULF COAST PLASTIC SURGERY

*Gregory P. Pisarski, MD, FACS*

I would like additional information on:

- ( ) Tummy Tuck
- ( ) Smart Liposuction
- ( ) Renuvion
- ( ) Gynecomastia
- ( ) Eyelid Surgery
- ( ) Brow Lift
- ( ) QuickLift/ Face/Neck Lift
- ( ) MyEllevate
- ( ) Breast Augmentation
- ( ) Breast Uplift / Reduction
- ( ) Botox/Dysport
- ( ) Injectable Fillers
- ( ) HD-PDO Threads
- ( ) PlexR
- ( ) ThermiVa

## PATIENT INFORMATION

**Name** _____ **Date**_____
(Last) (First) (M) Mr. Mrs. Miss Dr.

Birthdate____/____/____ Age _____ SS #_____Sex M F Ethnicity_____ Marital Status_____

Address_____ _____ D License # _____
(Street) (City) (State) (Zip)

HM phone # _____ WK phone # _____ CELL phone # _____

Place of employment (parent if minor)_____Occupation _____

Family Physician _____ Phone #_____

Email _____ *May we contact you by email?* Y N

*May we contact you at work?* Y N *Do you wish phone calls to be confidential*? Y N

## FAMILY INFORMATION

Spouse (Parent) Name(s)_____SS #_____ D.O.B.___/___/___

Place of employment _____ WK phone # _____

In case of Emergency Contact: _____ Relation to patient _____

Address_____HM phone #_____
(Street) (City) (State) (Zip)

Neighbor or Relative (not living with you) _____ Relation to patient _____

Address_____HM phone #_____
(Street) (City) (State) (Zip)

## INSURANCE AND BILLING INFORMATION (ALL BLANKS MUST BE FILLED OUT)

**Person responsible for account** _____ Relation to patient _____
(If other than self)

Address_____ Phone # _____

**PRIMARY INSURANCE** _____ ID#_____ Group #_____

Name of Policy Holder _____Relation to pt_____ SS #_____

Address of Holder_____ Ph # _____ D.O.B.___/___/____
(If other than self)

**SECONDARY INSURANCE**_____ ID#_____ Group #_____

Name of Policy Holder _____Relation to pt_____ SS #_____

Address of Holder_____Ph # _____ D.O.B.___/___/____
(If other than self)

**How Did You Hear About Us?** _____

**Would you like to be contacted if we need training models for procedures, discounts are substantial?** Y N

# PATIENT MEDICAL HISTORY

**Name** _____ **Date**_____

**PURPOSE OF VISIT**_____

Medications (including nonprescription / aspirin) _____

_____

Medication Allergies: _____

Height _____ Weight _____ Pharmacy _____

**TOBACCO USE:** Do you Smoke Cigarettes? Y N Are you exposed to secondary smoke? Y N

**Current:** Packs/day _____ # of Years _____ **Past:** Quit Date: _____Packs/day _____ # of Years _____

Other Tobacco (check): ☐ Pipe ☐ Cigar ☐ Snuff ☐ Vape ☐ Nicotine Gum

Do you drink alcohol? Y N # of Drinks/week _____ Do you use marijuana/recreational drugs? Y N

Do you have a history of substance abuse? Y N

Are you pregnant? Y N # past pregnancies _____ Method of Birth Control _____

Have you had any problems with your health recently? Y N

If yes, what and when: _____

**PLEASE CHECK ANY ILLNESSES YOU HAVE OR HAVE HAD:**

| | | | |
|---|---|---|---|
| ☐ High Blood Pressure | ☐ Anemia | ☐ Hepatitis | ☐ Cancer _____ |
| ☐ Heart Disease/Problems | ☐ Cholesterol | ☐ VD / HIV / AIDS | ☐ Tuberculosis |
| ☐ Heart Attack | ☐ Diabetes | ☐ Rheumatic Fever | ☐ Hay Fever / Allergies |
| ☐ Stroke | ☐ Pneumonia | ☐ Skin Ulcers | ☐ Anxiety |
| ☐ Poor Circulation | ☐ Emphysema | ☐ Lupus | ☐ Mental Illness |
| ☐ Vein Problems | ☐ Asthma | ☐ Arthritis | ☐ Seizures |
| ☐ Blood Clots (DVT/PE) | ☐ Peptic Ulcer Disease | ☐ Reflux | ☐ Thyroid problems |
| ☐ Blood Disorders | ☐ Kidney Disorders | ☐ Epilepsy | ☐ Other _____ |

Past Surgeries & Dates _____

_____

Any complications with past surgeries or general anesthesia? Y N

If yes, explain: _____

DO YOU PRESENTLY HAVE OR HAVE YOU EXPERIENCED THE FOLLOWING:

| | | | |
|---|---|---|---|
| ☐ Difficulty Breathing | ☐ Fever Blisters | ☐ Sinus Problems | ☐ Abnormal Bleeding |
| ☐ Chest Pain | ☐ Frequent Headaches | ☐ Drug / Alcohol Abuse | ☐ Weight Loss / Gain |
| ☐ Fainting Spells | ☐ Persistent Cough | ☐ Psychiatric Problems | ☐ Swelling of Ankles |

# FAMILY MEDICAL HISTORY

Please identify any medical problems **BLOOD RELATIVES** have or have had:

| | | | |
|---|---|---|---|
| ☐ Birth/Genetic Defects | ☐ Skin Disease | ☐ Heart Disease/Problems | ☐ Tuberculosis |
| ☐ Asthma | ☐ Eye/ Ear Disorders | ☐ Anemia/Blood Disorders | ☐ Seizures / Convulsions |
| ☐ Bone/Joint Disorders | ☐ Cancer | ☐ High Blood Pressure | ☐ Mental Disease/Disorder |
| ☐ Rheumatoid Arthritis | ☐ Diabetes | ☐ Kidney Disease/Problems | ☐ VD / HIV / AIDS |
| ☐ Muscle Disorders | ☐ Thyroid Disease | ☐ Blood Clots (DVT/PE) | ☐ Other_____ |