PLASTIC SURGERY CENTER OF NASHVILLE

DEMOGRAPHIC SHEET

PATIENT NAME: _____

BIRTH DATE: ___/____/_____ **AGE:** _____ **SOCIAL SECURITY:** _____

PATIENT ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HOME PHONE: _____ **CELL PHONE:** _____

EMAIL ADDRESS: _____

MARITAL STATUS: _____ **SPOUSE'S FULL NAME:** _____

PATIENT'S EMPLOYER NAME/OCCUPATION:

_____

WHO REFERRED YOU TO OUR PRACTICE? _____

REASON FOR TODAY'S VISIT: _____

RESPONSIBLE PARTY'S INFORMATION

NAME: _____ **PHONE NUMBER:**_____

RELATIONSHIP TO PATIENT: SELF☐ SPOUSE☐ PARENT☐ **DATE OF BIRTH:** _____/_____/_____

Please initial in the space provided to the left.

_____I understand that I will be responsible for all payments for services rendered and that the PLASTIC SURGERY CENTER OF NASHVILLE, LLC, does not accept any form of insurance benefit or submit information for insurance claims.

_____ I hereby authorize THE PLASTIC SURGERY CENTER OF NASHVILLE, LLC to release information to any hospital or physician on referral by the office

I understand that I am financially responsible for all charges, whether or not they could be covered by insurance. In the event that my account should become delinquent, I agree to pay all costs of collection and reasonable attorney's fees. I understand that my signature or esignature recorded on this Demographic and Medical/Surgical History is a representation of my full signature.

Please email this Demographic and Medical/Surgical History packet to info@nashvillesurgery.com or bring it to your scheduled appointment.

SIGNATURE:_____ **DATE:** ____/_____/_____

RELATION TO PATIENT: SELF☐ SPOUSE☐ PARENT☐

MEDICAL/SURGICAL HISTORY

TO BE COMPLETED BY PSCON NURSE:

WEIGHT:_____ BLOOD PRESSURE: _____ DATE/INITIALS: _____

TO BE COMPLETED BY PATIENT:

HEIGHT: _____ WEIGHT: _____ IS YOUR WEIGHT STABLE? YES____ NO ____

PLEASE LIST ALL MEDICATIONS, CURRENT OR TAKEN IN THE LAST 6 MONTHS, INCLUDING OVER THE COUNTER MEDICATIONS / VITAMINS / HERBALS / DIET SUPPLEMENTS

MEDICATIONS: DOSAGE/AMOUNT: FREQUENCY:

LIST YOUR PREFERRED PHARMACY NAME AND TELEPHONE:_____ (____)____-_____

YOUR PHARMACY ADDRESS:_____

LIST ALL DRUG ALLERGIES: _____

ARE YOU A SMOKER: YES NO **EX-SMOKER?** YES NO **QUIT WHEN?** _____

HOW MUCH ARE (WERE) YOU SMOKING? _____ **HOW LONG**? _____

PLEASE SELECT ALL CURRENT AND/OR PAST MEDICAL CONDITIONS, IF APPLICABLE:

High blood pressure	breast cancer	skin cancer	bleeding tendency	hepatitis	dry eyes
Blood transfusions	diabetes	glaucoma	rheumatoid arthritis	stroke	depression
Irregular heart beat	lung disease	emphysema	asthma or wheezing	mental illness	
Heart disease	heart attack	chest pain	mitral valve prolapse	rheumatic heart disease	
Heart burn	epilepsy	tuberculosis	Intestinal ulcers or bleeding	bronchitis	

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS, SERIOUS ILLNESS, OR INJURY NOT ALREADY LISTED?
YES NO **If YES:** _____

DO YOU HAVE A PRIMARY CARE PHYSICIAN? YES NO

NAME: _____ **PHONE NUMBER**: _____

HAVE YOU EVER SEEN A CARDIOLOGIST? YES NO **DATE OF LAST EKG**: _____

NAME: _____ **PHONE NUMBER:** _____

MEDICAL/SURGICAL HISTORY

DO YOU WORK IN CHILD CARE? **YES** ☐ **NO** ☐ **OCCUPATION:** _____

DO YOU WORK IN HEALTH CARE? **YES** ☐ **NO** ☐ **OCCUPATION:** _____

DO YOU HAVE ANYONE YOU HELP CARE FOR WHO IS CHRONICALLY ILL, IN AND OUT OF HOSPITALS, NURSING HOMES, OR OTHER CARE FACILITIES: **YES** ☐ **NO** ☐

ANY PERSONAL HISTORY OF MRSA INFECTION? **YES** ☐ **NO** ☐ **FAMILY MEMBER?** **YES** ☐ **NO** ☐

ANY PERSONAL HISTORY OF BLEEDING PROBLEMS? **YES** ☐ **NO** ☐ **FAMILY MEMBER?** **YES** ☐ **NO** ☐

ANY PERSONAL HISTORY OF CLOTTING PROBLEMS? **YES** ☐ **NO** ☐ **FAMILY MEMBER?** **YES** ☐ **NO** ☐

(If yes, please select)

☐ **DVT (DEEP VEIN THROMBOSIS)** ☐ **PULMONARY EMBOLISM** ☐ **MTHFR** ☐ **ANTI-PHOSPHOLIPID ANTIBODY**
☐ **FACTOR V LEIDEN**

WHEN? _____ **NAME OF DOCTOR WHO TREATED YOU:** _____

LIST ALL SURGERIES THAT YOU HAVE HAD: (*Include Cosmetic Procedures*) **DATE:**

HAVE YOU OR ANYONE IN YOUR FAMILY EVER HAD UNUSAL REACTIONS TO ANESTHESIA?

(If yes, please select)

☐ **MUSCLE WEAKNESS** ☐ **JAUNDICE** ☐ **BREATHING PROBLEMS** ☐ **UNEXPECTED FEVERS**

DO YOU HAVE A HISTORY OF THE FOLLOWING: (If yes, please select)

☐ **BOTOX** ☐ **FILLERS** ☐ **LASER TREATMENTS** ☐ **NON-INVASIVE FAT REMOVAL/COOLSCULPTING**

DATE(S) OF LAST TREATMENT(S): _____

HAVE YOU BEEN DIAGNOSED WITH COVID-19?: **YES** ☐ **NO** ☐
(If yes, please complete the following section)

DID YOU REQUIRE ANY OF THE FOLLOWING:

HOSPITALIZATION (duration): **YES** ☐ **NO** ☐ _____DAYS SYMPTOMS AT DIAGNOSIS: _____

OXYGEN: **YES** ☐ **NO** ☐ RESIDUAL SYMPTOMS: _____

HAVE YOU RECEIVED THE COVID-19 VACCINATION?: **YES** ☐ **NO** ☐

(If yes, please select)

MODERNA ☐ **PFIZER** ☐ **OTHER:** _____ **DATE:** _____

_____ _____

PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**

TO BE COMPLETED BY WOMEN ONLY:

DATE OF LAST MAMMOGRAM: _____ **RESULTS:** NORMAL ☐ ABNORMAL ☐

DO YOU HAVE A FAMILY HISTORY OF BREAST CANCER? YES ☐ NO ☐ **WHO?** _____

ARE YOU HERE FOR EVALUATION OF BREAST AUGMENTATION / BREAST LIFT / REDUCTION: YES ☐ NO ☐

If YES: CURRENT BRA SIZE: _____ **WHAT IS YOUR GOAL SIZE? _____**

DO YOU HAVE A GYNECOLOGIST/OBGYN? YES ☐ NO ☐

NAME: _____ **PHONE NUMBER: _____**

DATE OF LAST PELVIC EXAM: _____

HOW MANY CHILDREN HAVE YOU HAD? _____ **BREASTFED?** YES ☐ NO ☐

PERSONAL HISTORY OF MISCARRIAGES? YES ☐ NO ☐ **HOW MANY**? _____

PERSONAL HISTORY OF INFERTILITY: YES ☐ NO ☐ **KNOWN CAUSE? _____**

DO YOU HAVE CONCERNS REGARDING VAGINAL LAXITY? YES ☐ NO ☐

DO YOU HAVE CONCERNS REGARDING URINARY INCONTINENCE? YES ☐ NO ☐

DO YOU HAVE CONCERNS REGARDING THE EXTERNAL APPEARANCE OF YOUR LABIA? YES ☐ NO ☐

IF YOU ANSWERED YES FOR THE THREE PREVIOUS QUESTIONS, PLEASE DESCRIBE:

DO YOU HAVE A RECENT HISTORY OF TAKING HORMONES OF ANY KIND? YES ☐ NO ☐
IF YES, PLEASE LIST NAME(S): _____
DO YOU HAVE A RECENT HISTORY OF BIRTH CONTROL OF ANY KIND? YES ☐ NO ☐
IF YES, PLEASE LIST NAME(S): _____

_____ _____

PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**