DAVID E. MARTIN M.D.

PLASTIC SURGERY

Diplomat American Board of Plastic Surgery
Member of American Society of Plastic Surgeons, Inc.
Member of Dallas Society of Plastic Surgeons

Today's Date- ___/____/20___

*Patient's Full Name*_____ *Male____ Female____*
*SS#-*_____*-*_____*-*_____*Marital Status*_____ *Age*_____ *Birth Date*____/_____/_____
*Address*_____
Street City State Zip
*Home Telephone #-(*_____*)*_____ *Business # (*_____*)*_____*ext*_____
*Cell #(*_____*)* _____ *E-Mail address-* _____
*Patient's Employer*_____
Spouse's Name _____*Phone# (*_____*)*_____

Who may we thank for referring you?_____

*Is this visit the result of: Accident?*_____ *Work related?*_____ *Date of injury*____/_____/_____

Responsible party if different from patient or if patient is a minor
*Full name*_____*Birth Date*_____
*SS#*_____

Primary Insurance:
*Company:*_____ *Address*_____
*Phone # (*_____*)*_____ *Policy #*_____*Group #*_____
*Insured's Name*_____ *Insured's SS#* _____*Relationship to Patient*_____

Person to Notify in case of Emergency if other than spouse:
*Name*_____ *Phone #(*_____*)*_____

Reason for consultation -what would like to change?

_____
_____
_____
*Height*_____ *Weight* _____*Your best weight is -*_____

Allergies or medication intolerance-_____
_____

*Your Regular Medications: name & dosage:*_____
_____
_____

Over the counter medications: including aspirin, diet pills, sleeping pills, vitamins, & herbs-
_____
_____

Have you been dependent on Drugs? Yes_____ No _____ or Alcohol? Yes_____ No _____

PLEASE CONTINUE ON NEXT PAGE!!

*Previous surgery:*_____

_____

_____

*Anesthesia problems: (nausea/vomiting, slow to wake up, high temperatures)-*_____

_____

Do you have a <u>FAMILY HISTORY</u> of- anesthesia problems? _____ Malignant Hyperthermia?_____high temperatures with anesthesia?_____ muscle spasms with anesthesia?_____ Blood clots? _____
Connective Tissue Diseases(Rheumatoid Arthritis, Scleroderma, Lupus?_____

*Past hospitalizations?*_____

Have <u>you</u> Ever Had:

Hepatitis or Jaundice	*Yes_____ No _____ if yes any recurrences?_____*		
Seizures	*Yes_____ No _____*	*Thyroid problems*	*Yes_____ No _____*
High Blood Pressure	*Yes_____ No _____*	*Ulcers*	*Yes_____ No _____*
Heart attack	*Yes_____ No _____*	*Cold Sores*	*Yes_____ No _____*
Heart Valve problems	*Yes_____ No _____*	*Stroke*	*Yes_____ No _____*
Blood Transfusion	*Yes_____No _____*	*Diabetes*	*Yes_____ No _____*
Emphysema or asthma,	*Yes_____ No _____*	*Blood Clots*	*Yes____ No _____*
Abnormal bleeding	*Yes_____ No _____*		

<u>Have you been tested for:</u>

Tuberculosis	*Yes_____ No _____*	*approx. Date_____*	*Results_____*
HIV	*Yes_____ No _____*	*approx. Date _____*	*Results_____*
Hepatitis	*Yes_____ No _____*	*approx. Date _____*	*Results_____*

*Condition of Teeth: Caps or dentures? Yes_____ No _____ Problem teeth:*_____
*Date of last physical _____Physician_____ Finding*_____
*EKG*_____ *Last blood work-*_____

*Do you Drink alcohol ___ Yes____ No How much & how often?*_____
Do you smoke ____ Yes ____No for how long? _____ yrs. How much- _____ packs/day.
***If you have stopped smoking**- for how long? _____*
Do you use any other tobacco products(snuff or dip) or use a nicotine patch?- _____

<u>FEMALE PATIENTS ONLY:</u>

*Anemia Yes_____ No _____Currently?*_____
*Children:(names & ages)*_____
*Did you breast feed?*_____ *For how long*_____
Do you plan on having more children? _____ If so- how soon? _____
Breast lumps? Yes_____ No _____ Biopsies?_____ Results_____
*Do you have a family history of breast cancer?*_____

_____

*Last mammogram:*_____ *Findings*_____ *Location*_____

_____

1.) The above information is current and correct to the best of my knowledge:
2.) You may use my photos to show to medical or non-medical audiences and I hereby authorize you to release my medical records to insurance companies.
3.) I give my permission to be treated by Dr.Martin and his staff and assign all benefits directly to Dr. Martin. I understand that I am responsible for payment for any services rendered, whether or not covered by insurance benefits. I assume full responsibility for my balance regardless of the status of my insurance claim.
4.) If computer imaging is used in my evaluation- I understand that the alteration is purely for the purpose of illustration and discussion and does not constitute an expressed or implied warranty as to my final results and appearance.

*Signature*_____