David E Martin, MD
Plastic Surgery

Date: ________/________/________

____ ______/______/______ ________ SEX: M / F
Patient Full Name Date of Birth Age

Address:____
Street City State Zip

__________________________ ___________________________ __________________
Cell Number Home Number email address

___________________________ ___________________________ _________________
Occupation Employer Work Number

Marital Status: ☐ Single ☐ Married __________________________Spouse's Name (if Applicable)
I wish to be contacted in the following manner:
- ☐ OK to leave message with detailed information on cell / home / work
- ☐ OK to receive detailed messages via text on cell
- ☐ OK to receive detailed messages via email

NOTE: TEXT AND EMAILS BETWEEN THE OFFICE AND PATIENT CANNOT BE GUARANTEED SECURE.

Who may we thank for referring you? ____

Primary Insurance: ____________________________SS# ________ - ________ - ________

Phone #_____________________ Policy # _____________________ Group#_________

Insureds Name: __________________________ Relationship to Patient: __________
Insureds SS# ________ - ________ - ________Secondary Insurance: _____________ Policy # ________________
Group#_________________

I authorize David E Martin, MD and staff to release my medical records to insurance companies

____
Signature (Patient or Guardian if Patient is under 18)

Medical History

Briefly- purpose of your visit:

____

Height: ________________ Weight: ________________ ideal weight: ________________

Current Prescription Medications:
name & dosage:

____
____
____

Over the counter Medications:
aspirin, diet/sleeping pills, vitamins & herbs

____
____
____

MEDICATION ALLERGIES OR INTOLLERANCES? ☐ YES ☐ NO

Please explain: ______________________________

ANESTHESIA PROBLEMS? (Nausea/Vomiting, slow to wake up, high temperatures, etc) ☐ YES ☐ NO

Please explain: ______________________________

SURGERIES/PROCEDURES THAT YOU HAVE HAD INCLUDING DATES:

____
____

PLEASE CIRCLE YES / NO

FAMILY HISTORY

Anesthesia Problems Y / N
Blood Clots Y / N
Scleroderma/ Lupus/ RA Y / N
Breast Cancer Y / N

TESTING

Tuberculosis Y / N
approx. date ________ results: + / -
HIV Y / N
approx. date ________ results: + / -
Hepatitis Y / N
approx. date ________ results: + / -

PERSONAL HISTORY

Hepatitis or Jaundice Y / N
any recurrences? ____________
Seizures Y / N
High Blood Pressure Y / N
Heart Attack/Stroke Y / N
Heart Valve Problems Y / N
Blood Transfusions Y / N
Emphysema or asthma Y / N
Abnormal Bleeding Y / N
Thyroid Problems Y / N
Ulcers Y / N
Cold Sores Y / N
Diabetes Y / N
Blood Clots Y / N

FEMALE PATIENTS ONLY

Anemia Y / N
Pregnancies: ________
Live Births: ___________
Plans for more children? Y / N
Did you breastfeed? Y / N

Breast Lumps Y / N
Breast Biopsies Y / N
Results: ____________________

Last Mammogram: _______________
Location: ____________________
Findings: ______________________

Personal Physician: ________________________________ Date of last physical:_____________ Results: ___________

Date of last bloodwork: _____________ Results: ___________ Date of last EKG: _____________ Results: ___________

Do you smoke? Y / N If so, for how long? _______________ How much: __________ packs/day
Have you stopped smoking before – for how long? _________ Do you use any other tobacco products? Y / N

Do you drink Alcohol? Y / N How much and how often? _________________________

Do you use recreational drugs of any kind? Y / N Which drugs and how often? _________________________

I certify that the above information is correct to the best of my knowledge.
If computer imaging is used in my evaluation – I understand that the alteration is purely for illustration and discussion and does not constitute an expressed or implied warranty as to my final results and appearance.

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