



The Plastic Surgery Institute of Washington

Aesthetic, Plastic and Reconstructive Surgery

Roger J. Friedman, MD, PC

Douglas L. Forman, MD, FACS

Kathy Huang, MD

Patient Information

Date ____/____/____

Male Female

Last Name _____

First Name _____

Middle Initial _____

Marital Status Single Married Divorced Widowed Separated

Age _____

Date of Birth ____/____/____

Home Address _____

SS# _____ - _____ - _____

Home Phone # (____) _____ - _____

Mobile Phone # (____) _____ - _____

Work # (____) _____ - _____

Email Address _____

Would you like to receive information on activities & events through email? Yes No

Referred by Dr. _____ Insurance Plan Hospital Internet

Friend _____ Family _____ Other _____

Occupation _____ Employer _____

Employer Phone # (____) _____ - _____

Primary Care Physician _____ Phone # (____) _____ - _____

Emergency Contact

Name _____ Relationship to patient _____

Home Phone # (____) _____ - _____ Mobile Phone # (____) _____ - _____ Work # (____) _____ - _____

Personal Health History

Reason for visit _____

Have you seen other plastic surgeons for the same reason? _____

Medical Problems

- Abnormal bleeding Yes No
- Anemia Yes No
- Asthma Yes No
- Cancer Yes No
 - Chemotherapy Yes No
 - Radiation Yes No
- Diabetes Yes No
- Fever Blisters/Herpes Yes No
- Frequent Headaches Yes No
- Heart Disease Yes No
- Hepatitis Yes No
- HIV+ Yes No
- High Blood Pressure Yes No
- Psychiatric Problems Yes No
- Seizures Yes No
- Stroke Yes No
- Thyroid problems Yes No
- Other (please list) _____

Previous Surgery

Year	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Hospitalizations

Year	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications – please list both prescribed and over-the-counter, including inhalers, eye drops, vitamins, and herbs

Drug	Strength	Frequency Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take aspirin? Yes No
Do you take ibuprofen? Yes No
(Advil, Motrin, Nuprin)

Allergies/Sensitivities

Previous reaction to anesthesia? Yes No
➤ Describe _____
Are you allergic to latex? Yes No
Are you allergic to any medications? Yes No

Drug	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Social History

Do you drink alcohol? Yes No
Do you currently smoke? Yes No
Have you smoked in the past? Yes No
Do you use recreational drugs? Yes No

For current smokers: I understand that smoking affects the blood supply to my tissues, which places me at increased risk for prolonged wound healing, blistering, and/or actual skin and tissue loss.

Signature x _____

Family History

	Age(s)	Significant Health Problems
➤ Father	_____	_____
➤ Mother	_____	_____
➤ Siblings	_____	_____
➤ Children	_____	_____

Has anyone in the family had any problems with anesthesia? Yes No
Has anyone in the family had unusual bleeding with surgery? Yes No

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature x _____ Date ____/____/____

Consent for Photographs

I understand that photographs are an important component in the process of plastic surgery. They are taken to allow both the patient and physician to identify asymmetries, abnormalities, and areas of concern. They also allow the physician to use computer imaging to better assist the patient in appreciating the goals of surgery and compare preoperative photographs with postoperative results.

I also understand that reconstructive procedures may require insurance preauthorization. To obtain this coverage, it may be necessary to send a letter and photographs prior to the surgery to enable the carrier to better appreciate the clinical situation.

Therefore, I consent to having my picture taken for medical documentation, patient education, and insurance.

Signature x _____ Date ____/____/____

Privacy Practices and Patient Rights

I have received the pamphlets "Notice of Our Privacy Practices" and "Your Rights as Our Patient" for Roger J. Friedman, MD, Douglas L. Forman, MD, and Kathy Huang, MD.

Signature x _____ Date ____/____/____