WELCOME TO OUR PRACTICE

Name____ D.O.B________________

Address_____________________________City_____________Zip____________

Primary Phone___________________ Secondary Phone_____________________

Email Address____

Would you like to receive our email newsletter for special news and promotions? Yes_____ No______

What is your preferred method of communication with our office?________________________________

Age________ Sex_______ Marital Status_________________SSN#______-_______-_______

Employer______________________________
Occupation______________________________

Spouse/Emergency
Contact____

Related by _____________________________________ Contact Phone ____________________

How Did You Hear About Dr. Pollack? (Circle all that apply)

A Friend A Physician Yellow Pages Internet Search Other________________

If you used the Internet, what Keywords did you use to search? _____________________________

Is there someone we can thank for referring you to us? ________________________________

Name____
Date________________________

Age__________ Height___________ Weight__________ Number of Pregnancies____________

WHAT COSMETIC PROCEDURES ARE YOU CURRENTLY INTERESTED IN?_______

____
____

____
____

PAST OPERATIONS: (PLEASE LIST TYPE AND YEAR):_____________________

____
____

____
____

Have you ever been told that you have any of the following? (check all that apply)

_____High Blood Pressure

_____Heart Disease

_____Diabetes

_____Thyroid Disease

_____High Cholesterol

_____Bleeding Problems

_____Blood Transfusions

_____Other Chronic Disease_______________

_____Cancer_____________________

Medications: Please list all current medications and dosage:

____

____

____

____

ALLERGIES

What Medications are you allergic to? What kind of reaction do you have to them?

____

____

HABITS

Please check all that apply:

_____Smoke Cigarettes _____Drink Alcohol

_____Special Diet _____Exercise Regularly

Notes:____

____

FAMILY HISTORY

Do any of the following diseases run in your family?

_____Diabetes _____Thyroid

_____High Blood Pressure _____Heart Disease

_____High Cholesterol _____Breast Cancer

_____Other Cancer

PREOPERATIVE INFORMATION

When was your last mammogram?_________________ Was it Normal?
____

Have you ever had a reaction to anesthesia?
____

Are you allergic to adhesive tape or other adhesives?
____

Do you have problems with healing, bruising or bleeding?
____

Do you have frequent skin infections?
____