GODWIN PLASTIC SURGERY

PATIENT REGISTRATION

First Name: _____ Middle: _____ Last Name: _____

DOB: _____ Age: _____ Sex: M _____ F _____

Street: _____ City: _____ State:_____Zip:_____

Cell Phone: _____ Other Phone: _____

Email: _____

May we leave a voicemail on either of these phone numbers? ◯ Yes ◯ No
May we send you text appointment reminders? ◯ Yes ◯ No

Emergency Contact: _____ Phone: _____

Reason for your visit today: _____

How were you referred to our office? (Check all that apply)
◯ Physician Referral: _____
◯ Friend: _____
◯ Facebook/Instagram
◯ Google
◯ Realself.com
◯ Billboard
◯ Other: _____

Plastic surgeons need to know your full health history to ensure your safety and health, and to determine if you're a good candidate for surgery.

It is very important for Godwin Plastic Surgery to document your allergies, medications, and medical history.

Hypertension, previous blood clots, diabetes, smoking, cardiac and respiratory symptoms do not prevent you from having an elective surgery but can increase the risks of complications.

Be certain to share all medical conditions with our office, to help ensure proper planning and safety before, during, and after your procedure.

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MEDICAL HISTORY

Name:_____ **Date:**_____

Do you have any drug allergies? ◯ Yes ◯ No Are you allergic to Latex? ◯ Yes ◯ No

Please list ALL drug allergies and the reaction. (if you have no allergies, please write "none") Thank you.

Drug Allergy	**Reaction**

Medical Conditions: _____

_____

Height: _____ Weight: _____ Are you at your preferred weight? _____

Please answer all the following:

Do you take blood thinners/aspirin?	YES	NO	Do you take antibiotics before procedures?	YES	NO
Do you have a pacemaker or defibrillator?	YES	NO	Do you have a history of cold sores?	YES	NO
Do you have coughing/shortness of breath?	YES	NO	Do you have breathing problems?	YES	NO
Do you have joint pain?	YES	NO	Are you pregnant or nursing? (circle one)	YES	NO
Do you have chest pain?	YES	NO	Do you have asthma?	YES	NO
Have you ever had a problem with anesthesia?	YES	NO	Do you have any infectious diseases? (HIV, Hepatitis B or C, TB, etc.)	YES	NO
Do you have diabetes?	YES	NO	Do you have high blood pressure?	YES	NO
Do you use diet pills? Do you take GLP-1's or similar meds?	YES YES	NO NO	Have you ever had cancer? Type: _____	YES	NO
Do you currently or in the past have you used any tobacco product?	YES	NO	Do you drink alcohol?	YES	NO
Do you take fish oil?	YES	NO	Have you had a recent mammogram? If yes, Date: _____	YES	NO

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MEDICAL HISTORY (continued)

Name:_____ Date: _____

Please list your full and complete surgical history to the best of your knowledge.

List your Surgical History	Date of Surgery

Family History:

Do you have any family members with a history of cancer? ◯ Yes ◯ No

Do you have any family members with a history of diabetes? ◯ Yes ◯ No

Do you have any family members with a history of heart disease? ◯ Yes ◯ No

Please list ALL prescription & over-the-counter medications you are currently taking:
(If not previously noted, please state why you are taking this medication)

Medication Name	**Dose**	**Frequency**

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