Paul Rottler, M.D., F.A.C.S.
Plastic & Reconstructive Surgery

Patient:_______________________________________Date:________________

Address:____

City______________________State__________Zip________County__________

Home Ph#: ______________Height: _____Weight: _______SS#______________

Date of Birth:____________Age:________Sex: M F Marital Status: S M D W

Race: __ Caucasian, __ African American, __ American Indian/Alaska Native, ___ Asian, __Native Hawaiian/Pacific Islander, __ Hispanic/Latino, __ Multi-racial

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GENERAL INFORMATION

Patient

Occupation__________________

Employer__________________

Work Phone#_______________

Cell Phone#_________________

E-mail________________________

Best# to Call: Hm Wk Cell

Best time to call:______

Spouse or Nearest Relative

Name_________________________

Address________________________

Home Phone#___________________

Employer________________________

Work Phone#__________________

ABOUT YOUR VISIT

Who referred you to our office?____

Who is your primary physician?____

Why are you coming to our office?____

RELEASES

- I hereby give consent to have photographs made of me by Paul Rottler, M.D. or his assistants and understand they will be kept confidential in my medical record.
- I authorize Dr. Rottler to release or obtain medical information required in the course of my exam or treatment.
- I am financially responsible for my bill.

________________________________ ____________________

Signature of patient Date

****(Please turn over and continue)****

MEDICAL HISTORY

Patient Medical History

Diabetes	No Yes
Hypertension	No Yes
Cancer	No Yes
Stroke	No Yes
Heart trouble	No Yes
Arthritis	No Yes
Convulsions	No Yes
Bleeding disorder	No Yes
Acute infections	No Yes
Venereal disease	No Yes

Patient Social History

Use of alcohol Never____Rarely____Moderate____

Use of tobacco None______Yes - packs/day________

Use of drugs Never_____Type/frequency_________

Family Medical History

	Age	Present Health
Father	________	___________________________
Mother	________	___________________________
Siblings	________	___________________________
	________	___________________________
	________	___________________________
	________	___________________________
Children	________	___________________________
	________	___________________________
	________	___________________________

System Review

Constitutional symptoms-

Good general health lately	No Yes
Recent weight change	No Yes

Eyes-

Wear glasses/contact lens	No Yes
Glaucoma	No Yes

Ears/Nose/Mouth/Throat-

Earaches	No Yes
Chronic sinus problems	No Yes
Nose bleeds	No Yes
Mouth sores	No Yes
Sore throat or voice change	No Yes
Swollen glands in neck	No Yes

Respiratory-

Chronic/frequent cough	No Yes
Spitting up blood	No Yes
Asthma/wheezing	No Yes

Cardiovascular-

Chest Pain or angina	No Yes
Palpitation	No Yes
Shortness of breath	No Yes
Swelling of feet or ankles	No Yes

Gastrointestinal-

Nausea/vomiting	No Yes
Diarrhea/constipation	No Yes
Frequent heartburn	No Yes

Genitoutinary-

Frequent urination	No Yes
Painful urination	No Yes
Blood in urine	No Yes

Musculoskeletal-

Joint pain	No Yes
Joint stiffness/swelling	No Yes
Muscle pain/cramps	No Yes

Integumentary-

Rash or itching	No Yes
Change in skin color	No Yes
Varicose veins	No Yes
Breast pain or lumps	No Yes

Neurological-

Frequent headaches	No Yes
Numbness/tingling	No Yes
Paralysis	No Yes

Psychiatric-

Nervousness	No Yes
Depression	No Yes
Insomnia	No Yes
Admitted to psychiatric facility in the past	No Yes

Allergic/Immunologic-

History of reaction to:

Penicillin	No Yes
Morphine/Demerol	No Yes
Novacain	No Yes
Aspirin	No Yes
Sulfa drugs	No Yes
Latex	No Yes
Other drugs__________________	No Yes

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Current Medication Usage-

____

____

____

____

List all surgeries you have had in the past-

Surgery	Year

____

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