# 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: Female Marital Status: Single

Race: Caucasian

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## GENERAL INFORMATION

### Patient

Occupation _____

Employer _____

Work Phone# _____

Cell Phone _____

E-mail

Best# to Call: Cell

Best time to call: Morning

### Spouse or Nearest Relative

Name _____

Address _____

Home Phone# _____

Employer _____

Work Phone# _____

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## ABOUT YOUR VISIT

Who referred you to our office? _____ or ☐ **Online Search** ☐ **Other**_____

Who is your primary physician?_____

Why are you coming to our office?_____

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## RELEASES

- I hereby give consent to have photographs/videos 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

# MEDICAL HISTORY

Patient Medical History

Have you been diagnosed with any of the following: (Check all that apply)

| | | | |
|---|---|---|---|
| Diabetes | ☐ | Arthritis | ☐ |
| Hypertension | ☐ | Convulsions | ☐ |
| Cancer | ☐ | Bleeding Disorder | ☐ |
| Stroke | ☐ | Acute infections | ☐ |
| Heart trouble | ☐ | Venereal disease | ☐ |

Surgical History

Surgery Year

_____

_____

_____

_____

Current Medications

_____

_____

_____

_____

Drug Allergies

History of reaction to:

Penicillin ☐

Morphine/Demerol ☐

Novacain ☐

Aspirin ☐

Sulfa drugs ☐

Latex ☐

Other _____

Patient Social History

Use of Alcohol Never

Use of Tobacco No Packs/day_____

Use of Drugs No Type/frequency_____

Family Medical History

| | Age | Present Health |
|---|---|---|
| Father | _____ | _____ |
| Mother | _____ | _____ |
| Siblings | _____ | _____ |
| | _____ | _____ |
| Children | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |

Review of Systems (Check all that apply)

*Constitutional symptoms-*

- Good general health lately ☐
- Recent weight change ☐

*Eyes-*

- Wear glasses/contact lens ☐
- Glaucoma ☐

*Ears/Nose/Mouth/Throat-*

- Earaches ☐
- Chronic sinus problems ☐
- Nose bleeds ☐
- Mouth sores ☐
- Sore throat or voice change ☐

*Respiratory-*

- Chronic/frequent cough ☐
- Spitting up blood ☐
- Asthma/wheezing ☐
- Tuberculosis ☐

*Cardiovascular-*

- Chest Pain or angina ☐
- Palpitation ☐
- Shortness of breath ☐
- Swelling of feet or ankles ☐

*Gastrointestinal-*

- Nausea/vomiting ☐
- Diarrhea/Constipation ☐
- Frequent Heartburn ☐

*Genitoutinary-*

- Frequent urination ☐
- Painful urination ☐
- Blood in urine ☐

*Musculoskeletal-*

- Joint pain ☐
- Joint stiffness/swelling ☐
- Muscle pain/cramps ☐

*Integumentary-*

- Rash or itching ☐
- Change in skin color ☐
- Varicose veins ☐
- Breast pain or lumps ☐

*Neurological-*

- Frequent headaches ☐
- Numbness/tingling ☐
- Paralysis ☐

*Psychiatric-*

- Anxiety ☐
- Depression ☐
- Insomnia ☐
- Admitted to psychiatric facility in the past ☐