COTTER
plastic surgery

WELCOME! Thank you for selecting COTTER PLASTIC SURGERY! Please complete this form in **ink**.
If you have any questions or need assistance please ask, we will be happy to help!

Personal Information

Date:_____ Patient Name:_____ Prefers to be called:_____

Birthdate:_____ Current Age:_____ ☐ Male ☐ Female Soc. Sec. #:_____

Address:_____City:_____State:_____ Zip:_____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Cell Phone Carrier:_____ Email:_____

Where do you prefer to receive calls? ☐ Cell ☐ Home ☐ Work
When do you prefer to receive calls? ☐ AM ☐ PM ☐ I have no preference

Employer: _____ Occupation:_____

Physician Referral:_____ Other Referral:_____

Family/ PCP Physician:_____ Specialists:_____

In the event of an emergency, please contact:_____ Phone:_____

Insurance Information

Who is responsible for your insurance coverage? ☐ Self ☐ Other, if other complete below

Name:_____ Relationship to Patient:_____ Date of Birth: _____

Address:_____City:_____State:_____ Zip:_____

Day Time Phone:_____ Email:_____ Employer:_____

PRIMARY Insurance Carrier:_____ Policy #: _____

SECONDARY Insurance Carrier:_____ Policy #:_____

OTHER:_____

Antibiotics: Have you ever been instructed to take antibiotics prior to surgery? ☐ Yes ☐ No

Surgical History: Please list ALL surgeries and the approximate date of the surgery.

PROCEDURE	DATE	PROCEDURE	DATE

Anesthesia: Have you ever had problems with: ☐ Local Anesthesia ☐ IV Sedation ☐ General Anesthesia

Medications: Please list ALL medications taken on a regular basis (include Aspirin, Ibuprofen, Coumadin, Herbal Meds, etc.)

1. _____ **5.** _____
2. _____ **6.** _____
3. _____ **7.** _____
4. _____ **8.** _____

Pharmacy Preference: Name/Location _____ Telephone: _____

Allergies: Are you allergic to any drugs, anesthetic agents or other materials? (e.g., tape, iodine, food) ☐ NO ☐ YES
If YES, please note: _____

Personal History: Height: _____ Current Weight: _____ Maximum Weight: _____

Do you live: ☐ Alone ☐ w/Family ☐ w/Roommate ☐ Retirement Community ☐ Nursing Home

Do you smoke? ☐ No ☐ Yes / Do you Vape? ☐ No ☐ Yes If yes, how much? _____

Do you drink alcoholic beverages on a regular basis? ☐ No ☐ Yes ☐ Socially

Family History: Please answer ALL

	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Diabetes	____	____	_____	Breast Cancer	____	____	_____
Hypertension	____	____	_____	Other Cancer	____	____	_____
Heart Disease	____	____	_____	Stroke	____	____	_____
Melanoma	____	____	_____	Bleeding Problem	____	____	_____
Skin Cancer	____	____	_____	Other	_____		_____

Females Only:

Are you pregnant? ☐ No ☐ Yes
Have you had breast implant surgery? ☐ No ☐ Yes If yes, are your implants ☐ Saline ☐ Silicone ☐ _____

Patient Signature: _____ **Date:** _____

MEDICAL & SURGICAL HISTORY

PATIENT NAME: _____ DATE: _____

CHECK ALL THAT APPLY → → CHECK NONE, IF NONE APPLY → → *Thank you!*

GENERAL & HORMONAL
- ☐ Eating Disorder
- ☐ Thyroid Disease
- ☐ Chronic Fatigue Syndrome
- ☐ Chronic Disease
- ☐ Cancer TYPE_____
- ☐ Non-insulin Dependent Diabetes
- ☐ Insulin Dependent Diabetes
- ☐ OTHER: _____
- ☐ **NONE**

INTEGUMENT (SKIN)
- ☐ Skin Cancer ☐ Melanoma
- ☐ Dysplastic Nevi ☐ Acné
- ☐ Rosácea ☐ Eczema
- ☐ Psoriasis
- ☐ OTHER: _____
- ☐ **NONE**

BREAST – Right / Left / Bilateral

☐ Biopsy	R	L	B
☐ Cyst Drained	R	L	B
☐ Lumpectomy	R	L	B
☐ Mastectomy	R	L	B
☐ Reconstruction	R	L	B
☐ Implant(s)	R	L	B

- ☐ OTHER: _____
- ☐ **NONE**

HEAD & NECK
- ☐ Trauma ☐ Neurosurgery
- ☐ Facial Surgery
- ☐ Brain Shunt
- ☐ Thyroid Surgery
- ☐ Cervical Disc Surgery
- ☐ Arthritis in Neck
- ☐ Lymph Node Removed
- ☐ Cervical Disc Disease
- ☐ Carotid Artery Surgery
- ☐ Thyroid Surgery
- ☐ OTHER: _____
- ☐ **NONE**

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Pins and/or screws for fracture
- ☐ Knee &/or ☐ Hip Replacement
- ☐ Back Surgery
- ☐ OTHER: _____
- ☐ **NONE**

EYES / EARS / NOSE
- ☐ Glaucoma
- ☐ Cataract Surgery
- ☐ Eye Muscle Surgery
- ☐ Eyelid Surgery
- ☐ Hearing Aid
- ☐ Cochlear Surgery
- ☐ Skin Cancer Surgery
- ☐ Ears "pinned back
- ☐ Sinus Surgery
- ☐ Nasal Surgery/Broken Nose
- ☐ Septal Surgery ☐ Rhinoplasty
- ☐ OTHER: _____
- ☐ **NONE**

CARDIOVASCULAR & RESPIRATORY
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Chest Pain
- ☐ Heart Rhythm Abnormality
- ☐ Heart By-pass Surgery
- ☐ Heart Valve Surgery
- ☐ Mitral Valve Prolapsed
- ☐ Implanted Defibrillator
- ☐ Aneurysm Repair
- ☐ OTHER: _____
- ☐ **NONE**

GASTROINTESTINAL
- ☐ Gastric By-pass Surgery
- ☐ Hernia Repair
- ☐ Gallbladder Surgery
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Colon Cancer
- ☐ OTHER: _____
- ☐ **NONE**

GENITOURINARY - WOMEN
- ☐ Hysterectomy
- ☐ Endometriosis
- ☐ Ovarian Cysts
- ☐ Abnormal PAP
- ☐ Childbirth # _____
- ☐ C-Section # _____
- ☐ OTHER: _____
- ☐ **NONE**

GENITOURINARY - MEN
- ☐ Testicular Surgery
- ☐ Penile Prosthesis
- ☐ OTHER: _____
- ☐ **NONE**

GENITOURINARY – ALL
- ☐ Biopsy: _____
- ☐ Lesion Removed ☐ Hernia Repaired ☐ Kidney Stones
- ☐ Kidney Transplant
- ☐ Kidney Disease
- ☐ OTHER: _____
- ☐ **NONE**

NERVE/NEUROLOGIC & PSYCHIATRIC
- ☐ Neuropathy ☐ Shingles
- ☐ Seizure Disorder
- ☐ Stroke ☐ Migraines
- ☐ Headaches
- ☐ Carpal Tunnel Syndrome
- ☐ Depression
- ☐ Drug Dependency
- ☐ Alcoholism
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Anxiety Disorder
- ☐ ADHD/ADD
- ☐ OTHER: _____
- ☐ **NONE**

BLOOD DISEASE & IMMUNE SYSTEM
- ☐ Anemia ☐ Leukemia
- ☐ Sickle Cell Syndrome
- ☐ Fibromyalgia
- ☐ High Platelet Count
- ☐ Low Platelet Count
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma ☐ Lupus
- ☐ Organ Transplant
- ☐ Lymphoma
- ☐ Hodgkin's disease
- ☐ HIV/AIDS
- ☐ OTHER: _____
- ☐ **NONE**

REVIEW of SYSTEMS

CHECK ALL THAT APPLY → → CHECK NONE, IF NONE APPLY → → SIGN & DATE at the bottom. *Thank you!*

GENERAL/CONSTITUTIONAL
☐ Fever ☐ Fatigue or Malaise
☐ Flu-like Symptoms
☐ Unexplained Weight - / +
☐ OTHER: _____ ☐ **NONE**

HEAD/SKULL
☐ Lumps ☐ Irregularities
☐ Pain ☐ Lesions
☐ Congenital / Surgical Defects
☐ OTHER: _____ ☐ **NONE**

EYES
☐ Blurred/Double Vision
☐ Loss of Vision
☐ Difficulty Seeing at Night
☐ Irritated, Itchy, Watery
☐ Eye Pain ☐ Discharge
☐ OTHER: _____ ☐ **NONE**

EARS
☐ Pain/Earache ☐ Drainage
☐ Difficulty Hearing ☐ Dizziness
☐ Ringing in the Ears
☐ OTHER: _____ ☐ **NONE**

NOSE
☐ Pain ☐ Irritation ☐ Drainage
☐ Discharge ☐ Loud Snoring
☐ Problems Breathing
☐ OTHER: _____ ☐ **NONE**

THROAT
☐ Pain ☐ Sore ☐ Hoarseness
☐ Irritation / Redness
☐ Trouble Swallowing / Speaking
☐ OTHER: _____ ☐ **NONE**

NECK
☐ Pain or Stiffness ☐ Growths
☐ Lumps/ Bumps ☐ Lymph Nodes
☐ OTHER: _____ ☐ **NONE**

RESPIRATORY
☐ Cough ☐ Short of Breath
☐ Sputum Production
☐ Cough Blood ☐ Wheezing
☐ Pain w/ Deep Breath
☐ Stop Breathing when Sleeping
☐ OTHER: _____ ☐ **NONE**

PSYCHIATRIC
☐ Frequently Depressed
☐ Constant Anxiety ☐ Paranoia
☐ Memory Loss ☐ Suicidal Thoughts ☐ Hallucinations
☐ OTHER: _____ ☐ **NONE**

MUSCULOSKELETAL
☐ Joint Pain, Swelling
☐ Muscle Pain, Stiffness
☐ Upper Back Pain ☐ Lower Back Pain ☐ Shoulder Pain
☐ OTHER: _____ ☐ **NONE**

GASTROINTESTINAL
☐ Nausea/Vomiting ☐ Chronic Diarrhea ☐ Chronic Constipation
☐ Change in Bowel Habit
☐ Abdominal Pain ☐ Frequent Dark Black Stools ☐ Blood in Stools
☐ Jaundice (yellow skin)
☐ Pain/Discomfort after Eating
☐ OTHER: _____ ☐ **NONE**

GENITOURINARY-WOMEN
☐ Vaginal Irritation/Discharge
☐ Menstrual Irregularities
☐ OTHER: _____ ☐ **NONE**

GENITOURINARY – ALL
☐ Pain/Discharge w/ Urination
☐ Frequent/Urgent Urination
☐ Recent Change in Urinary Habits
☐ Rashes, Sores, Growths
☐ OTHER: _____ ☐ **NONE**

NEUROLOGIC
☐ Seizures ☐ Tremors
☐ Weakness ☐ Numbness
☐ Tingling ☐ Poor Balance
☐ Difficulty Walking ☐ Dizziness
☐ Temp Paralysis ☐ Inability to talk
☐ OTHER: _____ ☐ **NONE**

PROVIDER INITIALS _____

DATE _____

CARDIOVASCULAR
☐ Chest Pain ☐ Palpitations / Skipped Beats ☐ Fainting Spells
☐ Leg Swelling ☐ Shortness of Breath on Exertion ☐ Shortness of Breath if Sleeps Flat
☐ OTHER: _____ ☐ **NONE**

INTEGUMENTARY (SKIN)
☐ Painful Are ☐ Rash, Itching, Dryness ☐ Unusual Lesions/Crusted Areas ☐ Wounds/Lumps/Bumps
☐ Acne ☐ Redness ☐ Drainage
☐ OTHER: _____ ☐ **NONE**

ENDOCRINE (HORMONAL)
☐ Increased Hunger ☐ Increased Thirst ☐ Frequent Urination
☐ Heat or Cold Intolerance
☐ Excessive Sleepiness after Meals
☐ Tingling and/or Numbness in Fingers and/or Toes
☐ OTHER: _____ ☐ **NONE**

BREAST
☐ Lumps, Bumps, Dimpling
☐ Drainage/ Discharge ☐ Pain
☐ Change in Size ☐ Shoulder Grooving ☐ Stretch Marks
☐ OTHER: _____ ☐ **NONE**

HEMATOLOGIC
☐ Abnormal or Prolonged Bleeding
☐ Bruising ☐ Fatigue ☐ Pallor
☐ OTHER: _____ ☐ **NONE**

ALLERGIES
☐ Frequent Sneezing ☐ Itchy / Watery
☐ Runny Nose ☐ Hay Fever / Hives
☐ OTHER: _____ ☐ **NONE**

IMMUNOLOGIC
☐ Exposure to HIV/AIDS ☐ Exposure to Hepatitis
☐ Frequent or Persistent Infections
☐ Slow to Heal
☐ Enlarged Lymph Nodes or Glands in Axillary area, Groin, or Neck
☐ OTHER: _____ ☐ **NONE**

Patient Signature _____ Date _____