POLITIS
PLASTIC SURGERY

Patient Intake Form

Name: _____ DOB: _____

EMPLOYMENT INFORMATION

☐ Full Time | ☐ Part Time | ☐ Student | ☐ Retired Occupation: _____

Employer/School: _____

Does your job require? ☐ Sedentary (desk job) ☐ Moderate Activity ☐ Strenuous Activity

REFERRAL INFORMATION

Referring Physician or Patient: _____

How did you hear about Dr. Politis? _____

PROCEDURE INFORMATION

What is the reason for your visit today? [Check all applicable procedures below]

FACE	BREAST	BODY	SKIN
☐ Facelift	☐ Augmentation	☐ Liposuction	☐ Jeuveau Injections
☐ Cheek lift	☐ Lift (Mastopexy)	☐ Tummy Tuck	☐ Facial Fillers
☐ Brow Lift	☐ Revision/Repair	☐ Mommy Makeover	☐ Fat Injections
☐ Neck Lift	☐ Implant Exchange	☐ Body Lift	☐ Hand Rejuvenation
☐ Liquid Facelift	☐ Capsulectomy	☐ Arm Lift (Brachioplasty)	☐ Hyperhidrosis
☐ Facial Fat Transfer	☐ Reduction	☐ Thigh lift	☐ Mole Removal
☐ Facial Implants	☐ Asymmetry	☐ Fat Transfer	☐ Other:
☐ Lip Augmentation	☐ Reconstruction	☐ Other:	
☐ Chin Augmentation	Other:		
☐ Ear Reshaping			
☐ Upper Eyelids			
☐ Lower Eyelids			
☐ Rhinoplasty			
Other:			

Please describe why you are interested in having the procedure(s) listed above: _____

_____

Have you consulted with other physicians about the procedure(s) indicated above? ☐ Yes ☐ No

Is this procedure a revision from a previous surgery? ☐ Yes ☐ No

If Yes, how many previous surgeries? _____

What is your time preference for your procedure? Within the next: ☐ Month | ☐ 3 Months | ☐ 6 Months | ☐ 1 Year

PERSONAL PAST MEDICAL HISTORY

Do you have any chronic medical problems? [Please check all that apply]

☐ High Blood Pressure	☐ Diabetes	☐ HIV or AIDS	☐ Heart Disease
☐ Heart Failure	☐ Seizures	☐ Heart Attack	☐ Chest Pain
☐ Asthma	☐ Kidney Disease	☐ Psychiatric Diagnosis	☐ Bleeding Problems
☐ Liver Disease	☐ Gastric Reflux	☐ Cancer	☐ Stroke
☐ Hepatitis	☐ Emphysema	☐ Stomach Problems	☐ Breast Cancer

☐ Other: _____

Please explain any yes answers: _____

Is there a personal or family history of anesthetic complications or malignant hyperthermia? ☐ Yes | ☐ No

If yes, please explain? _____

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BREAST HISTORY

Have you ever had a breast mass, suspicious biopsy, or breast cancer? ☐ Yes | ☐ No
Do you have a family history of breast cancer? ☐ Yes | ☐ No
Date of your last mammogram or breast imaging? _____
What is your current bra size? _____

FAMILY HISTORY

Do you have a family history of any medical problems? [Please check all that apply]
Please indicate Family member(s): _____

☐ High Blood Pressure	☐ Diabetes	☐ HIV or AIDS	☐ Heart Disease
☐ Heart Failure	☐ Seizures	☐ Heart Attack	☐ Chest Pain
☐ Asthma	☐ Kidney Disease	☐ Psychiatric Diagnosis	☐ Bleeding Problems
☐ Liver Disease	☐ Gastric Reflux	☐ Cancer	☐ Stroke
☐ Hepatitis	☐ Emphysema	☐ Stomach Problems	☐ Breast Cancer

☐ Other: _____

Please list all prior surgical procedures: Date
1. _____ _____
2. _____ _____
3. _____ _____

Please list all prior Hospitalizations: Date
1. _____ _____
2. _____ _____
3. _____ _____

Please list ALL medications and/or dietary supplements that you are taking, including: (Prescriptions, Over the Counter Medications, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Flax Seed Oil, and St. John's Wort)

	DRUG NAME	**STRENGTH**	**FREQUENCY TAKEN**
1.			
2.			
3.			
4.			
5.			

Please list anything that you are **ALLERGIC** to (medications, food, insects, etc.) **and** your reaction

	ALLERGY	**REACTION**
1.		
2.		
3.		

SOCIAL HISTORY

Do you now, or have you ever smoked tobacco products? ☐ Yes | ☐ No
If Yes, # of packs per day: _____ # of years: _____ When did you quit? _____
Do you smoke e-cigarettes or vape? ☐ Yes | ☐ No Do you use recreational drugs? ☐ Yes | ☐ No
Do you drink alcohol? ☐ Yes | ☐ No If yes, ☐ Occasionally ☐ <3 times/week ☐ > 3 times/week
Do you exercise? ☐ Yes | ☐ No If yes, ☐ None ☐ Occasional ☐ < 3 times/week ☐ > 3 times/week

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner