# RICHARD PAVESE, M.D.

**PLASTIC AND RECONSTRUCTIVE SURGERY**

*Check box if you are a previous patient* ☐
*Former name?* ____________________

**PATIENT INFORMATION:** **DATE:** ____________________

Name: ______________________________ Age:________ Birth date: ________________

Address:______________________________ City:______________ State:________ Zip:__________

Occupation: ______________________________ Social Security #: ______________________

Phone: (H) ____________________ (Cell)____________________ (Work)______________________

Emergency Contact:______________________ Relationship: ______________ Phone #:________________

***Would you like to receive updates regarding new technology, procedures and events?***

***Yes*** _____ ***No*** _____ ***How do you wish to be contacted?***

***Your E-mail address*** ______________________________ ***Other*** ________________________

How were you referred to our office?______________________________________________

If referred by a previous patient, may we send them a thank you note for referring you here? ☐ YES ☐ NO

Reason for consultation: ______________________________________________________

Have you seen other surgeons for the same reason that brings you here today? ☐ YES ☐ NO

Are there any other topics which may be of interest to you?_______________________________

☐ Nose
☐ Tummy
☐ Face
☐ Eyes
☐ Breast

☐ Lipo
☐ Botox
☐ Spider Veins
☐ Facial Fillers

☐ Mineral Make-up
☐ Photofacials
☐ Lip Enhancement
☐ Microdermabrasion

Cosmetic surgery procedure fees are discussed on an individual basis. All cosmetic surgery fees must be paid 14 days prior to surgery date. **SURGERY DEPOSITS ARE NON-REFUNDABLE.**

______________________________ ______________________
Signature Date

# RICHARD PAVESE, M.D.

**PLASTIC AND RECONSTRUCTIVE SURGERY**

Name: ______________________________________________ Date: ______________

**MEDICAL HISTORY:** **Drug Allergies:** ____________________________________________

Age:________ Weight:____________ Height: _____________

Surgeries/Hospitalizations (give year): ____________________________________________

______________________________________________________________________

______________________________________________________________________

Past history of illnesses? ☐ YES ☐ NO If yes, explain: ______________________________

Are you currently being treated for any illnesses? ☐ YES ☐ NO If yes, please explain:______________

______________________________________________________________________

Current Medications: (prescription & over-the-counter: i.e., Aspirin, vitamins, herbs, supplements, diet pills)

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Please check if you have any of the following: *If none, check here* ☐

☐ Cancer ☐ Diabetes ☐ Asthma ☐ Shortness of Breath ☐ Anxiety ☐ Rheumatic Fever

☐ Mitral Valve Prolapse ☐ Angina ☐ High Blood Pressure ☐ Heart Attack ☐ Irregular Heart Rate

☐ Any Problem with Anesthesia ☐ Bleeding Disorders

Other significant health problems? ☐ YES ☐ NO Please explain:_____________________________

______________________________________________________________________

FAMILY HISTORY:

Do you smoke? ☐ YES ☐ NO If yes, _________ packs per day

History of smoking? ☐ YES ☐ NO

History of illnesses that run in your family: _________________________________________

When was your last mammogram?_________________________

_______________________________________ _________________________

Signature Date