HUBBARD
Plastic Surgery & Skin Enhancement

Welcome to Hubbard Plastic Surgery

Today's Date:_____ Ms. ___Mr. ___Mrs. ___Miss. ___Dr. ___

Patient's Name: Last _____ First _____ M _____

How would you like our staff to address you? _____

Home Address: _____

City, State, Zip: _____

Home Phone: _____ Cell: _____ Work: _____

May we contact you at your home? YES / NO May we contact you on your cell? YES/ NO May we contact your work? YES NO
(When we call, we will say we are calling from your doctor's office)

E-Mail Address: _____

Date of Birth: _____

Emergency Contact Name:_____**Phone Number:** _____
(Required)

Name of Guardian (if under 18): _____

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____Phone Number: _____

Primary Insurance: _____ ID Number: _____

Secondary Insurance: _____ID Number: _____

Which procedure would you like to discuss today? _____

Whom may we thank for referring you? _____

How did you hear about us? ☐ Hubbard Plastic Surgery Website ☐ Doctor Referral ☐ Friend ☐Family ☐Google ☐Facebook ☐RealSelf ☐ASAPS ☐ASPS ☐Other: _____

- I represent to Dr. Hubbard and/or his staff that I am at least 18 years of age or accompanied by an adult. I consent to and authorize examination or treatment by Dr. Hubbard and/or his staff, if applicable.
- If applicable, I understand that I am responsible for my insurance co-pay and deductibles on the day of my visit. I am also obligated to notify the practice immediately of any changes to my coverage.
- I further understand in the State of Virginia, consent for HIV testing is assumed if there has been exposure to a healthcare worker.
- I authorize Dr. Hubbard or his designated staff member to access my electronic Health Records.

Patient/Guardian Signature: _____ **Date:** _____ **Staff Initials:** _____

MEDICAL/SURGICAL HISTORY

Age: _____ Height: _____ Weight: _____ Occupation: _____

List *all* known allergies, as well as reactions, even to materials below. □ NONE

ALLERGIES	REACTIONS	Include *any* of the following:
		Latex, Elastic, Eggs, Rubber Gloves, Soy, Chestnuts, Kiwi, Banana, Strawberry, Avocado, Carrot, C Papaya, Potato, Tomato, Melon, etc.

List *all* medications you are currently taking or have taken in the past 6 months below.

MEDICATIONS	DOSAGE	FREQUENCY	Include *any* of the following:
			Birth Control Pills, Aspirin, Ibuprofen, Diet Pills, Diabetic Medications, Steroids, Glaucoma Drops, Asthma Medications, Digoxin, Lanoxin, Nitroglycerin, Isordil, Inderal, Other Heart Medications, Lasix, Other Diuretics, High Blood Pressure Medications, Coumadin, Persantine, Tranquilizers, Sleeping Pills, Anti-Depressants, Pain Pills or Shots, Epilepsy Medications, Contraceptive Vaginal Ring

Has a doctor recommended treatment, evaluation or testing that you have not done or a medication you are not taking? □ **YES** □ **NO**

If **YES**, please explain:_____ **Can you walk up 2 flights of stairs without becoming short of breath?** □ **YES** □ **NO**
Have you used any of these in the past 6 months (circle): LSD Speed Cocaine Marijuana (any form including Edibles/Oil) Pain Killers Illicit drugs **NONE?**
If **YES**, What, and how often?_____ **How much alcohol do you drink per week?**_____

Do you smoke cigarettes □ **YES** □ **NO**
Use nicotine gum/patch □ **YES** □ **NO**
Use marijuana or THC smoke or vape □ **YES** □ **NO**
Do you use CBD □ **YES** □ **NO**
Do you Vape □ **YES** □ **NO**
Use E-cigarettes □ **YES** □ **NO**
Take edibles □ **YES** □ **NO**

Are you exposed to secondhand smoke, in any environment? □ **YES** □ **NO If you quit smoking, how long ago?**_____

Please check off any of the following medical conditions you *have* or *have had* in the past. □ **NONE**

□ High Blood Pressure	□ Intestinal Ulcers or Bleeding	□ Persistent Cough	□ Phlebitis (Vein Inflation)
□ Anemia	□ Blood Transfusions	□ Stroke	□ Night Sweats
□ Asthma	□ Glaucoma	□ Epilepsy	□ Weight Loss
□ Bleeding Tendency	□ Dry Eyes	□ HIV	□ Eating Disorder
□ Hepatitis	□ Colorblind	□ Heart Burn	□ Raynaud's Syndrome
□ Diabetes	□ Heart Disease	□ Drug or Alcohol Addiction	□ Lung Disease

Any other serious illness, injury, or hospitalization? □ **YES** □ **NO Explain**:_____

Have you had or tested positive for COVID? □ **YES** □ **NO**

Date if tested positive for Covid _____ **Date complete recovery** _____**Persistent problems or issues** _____

Do you have any of the following diabetic issues? □ Kidney problems □ Neuropathy □ Gastroparesis □ NONE

Have you ever been diagnosed and/or treated for a psychiatric illness or substance abuse of any type? □ **YES** □ **NO**

If **YES**, please specify:_____

Have you ever been diagnosed with sleep apnea? Do you have, think you might have or ever had sleep apnea? □ **YES** □ **NO**
Have you ever had a coronary stent? □**YES** □**NO**

Have you had corrective vision surgery in the past 6 months? □ **YES** □ **NO**

Females: **Is there any possibility that you may be pregnant at this time?** □ **YES** □ **NO** **How many deliveries?** _____ □ **N/A**
List *all* surgeries below that you have had including plastic surgery, hysterectomy, tubal ligation, etc. □ NONE
Surgery and Date:

_____

_____

Do you or your family have a history of blood clots, blood that clots too much, or pulmonary embolism? □ **YES** □ **NO**
Have you or anyone in your family ever had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems, unexpected fevers, cola-colored urine)? □ **YES** □ **NO**
Do you have any of the following: □ Loose or Chipped Teeth □ Caps □ Dentures □ Contact Lenses □ NONE
Have you ever seen a cardiologist? □ **YES** □ **NO** Physician Name:_____

Patient/Guardian Signature: _____ Date: _____ Staff Initials: _____