



# 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: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**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

Rev 1.2.2020

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_

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

ALLERGIES	REACTIONS	Include <b><i>any</i></b> of the following:
		Latex, Elastic, Eggs, Rubber Gloves, Soy, Chestnuts, Kiwi, Banana, Avocado, Carrot, Celery, 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 <b><i>any</i></b> 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 (even socially), use nicotine gum/patch, vape, or use E-cigarettes?  YES  NO Explain: \_\_\_\_\_

Are you exposed to second hand 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.

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Intestinal Ulcers or Bleeding | <input type="checkbox"/> Persistent Cough          | <input type="checkbox"/> Phlebitis (Vein Inflation) |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Blood Transfusions            | <input type="checkbox"/> Stroke                    | <input type="checkbox"/> Night Sweats               |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Glaucoma                      | <input type="checkbox"/> Epilepsy                  | <input type="checkbox"/> Weight Loss                |
| <input type="checkbox"/> Bleeding Tendency   | <input type="checkbox"/> Dry Eyes                      | <input type="checkbox"/> HIV                       | <input type="checkbox"/> Eating Disorder            |
| <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Lung Disease                  | <input type="checkbox"/> Heart Burn                | <input type="checkbox"/> Raynaud's Syndrome         |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart Disease                 | <input type="checkbox"/> Drug or Alcohol Addiction | <input type="checkbox"/> NONE                       |

Any other serious illness, injury or hospitalization?  YES  NO Explain: \_\_\_\_\_

Have you had or tested positive for COVID?  YES  NO If YES, please list date \_\_\_\_\_

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?  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: \_\_\_\_\_