Patient Information

170622-PIF

Name: _____ Date of Birth: ___/___/_____ Age: ___
First Middle Last MM DD YYYY

Address: _____
Street City State Zip

Cell Phone: _____ Permission to leave voicemail: ◯ Yes ◯ No
(XXX) XXX-XXXX

Email: _____ Primary Medical Doctor:_____

Ok to send appointment info, specials & communication via unencrypted email and text?
◯ Yes ◯ No

Gender: ____ Occupation: _____ Marital Status: _____

How did you hear about us? (Check all that apply)

◯ Google ◯ Facebook ◯ Twitter ◯ Instagram ◯ RealSelf ◯ Diehl Plastics ◯ Other _____

Emergency Contact Name & Relationship to Patient: _____
Emergency Contact Cell Phone:_____

Patient History

Height: _____ Weight: _____ Date of Last Physical: ___/___/_____
FT, IN LBS MM DD YYYY

Food/Drug Allergies: _____ Latex Allergy: ◯ Yes ◯ No

Current Medications / Supplements	Dose	Frequency

Former Smoker: ◯ Yes ◯ No Vaping: ◯ Yes ◯ No

Current Smoker: ◯ Yes ◯ No If answered "Yes", number of packs per day: _____

Tannan Plastic Surgery
10208 Cerny St, Suite 204, Raleigh, NC 27617
(919) 797-0996 www.tannanmd.com info@tannanmd.com

Have you been hospitalized for reasons other than normal childbirth? ◯ Yes ◯ No

Have your any relatives had any problems with anesthesia? ◯ Yes ◯ No

Do you think you may be pregnant? ◯ Yes ◯ No

Number of alcoholic drinks consumed daily: ___ Date of Last Mammogram: ___/___/_____
MM DD YYYY

Past Surgical History

Surgery	Year	Surgeon

Review of Systems

Do you currently have or have you ever had a problem with:

	Y	N
Heart trouble, High blood pressure		
Asthma, lung problems, shortness of breath		
Diabetes		
Liver problems, jaundice, hepatitis		
Chronic headaches		
Neck, leg or back pain		
Breast problems, discharge, breast biopsy, cancer		
Fainting		
Glaucoma		
Cancer		
Bleeding disorders		

	Y	N
Thyroid problems		
Convulsions/seizures		
Kidney Problems		
Skin problems		
Rheumatic fever		
Keloid scars		
Blood clots		
Stomach or intestinal problems		
Psychiatric problems, depression, anxiety		
Lupus, rheumatoid arthritis		
Miscarriages (list how many if yes)		

Please explain any answers marked "Yes" above:

_____

Please list any medical conditions you have: _____

_____

Any family history of significant illness like blood clot, diabetes, heart disease, melanoma, malignant hyperthermia? _____

I certify that the information above is true and correct to the best of my knowledge.

_____ _____ _____

Printed Name Signature Date

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