CENTRAL KENTUCKY PLASTIC SURGERY

DR. CHRISTOPHER MAREK
BOARD CERTIFIED PLASTIC SURGEON

REGISTRATION

DATE:_____ ☐ **NEW PATIENT** ☐ **ESTABLISHED PATIENT**

REFERRING SOURCE:_____ **REASON FOR VISIT:**_____

NAME:_____

MAILING ADDRESS:_____

_____
(CITY) (STATE) (ZIP) (COUNTY)

SS#:_____ **DOB:**_____ **MARITAL STATUS:** ☐ **S** ☐ **M** ☐ **W** ☐ **D**

EMPLOYER:_____ **OCCUPATION:**_____

EMPLOYER ADDRESS:_____

SPOUSE/GUARDIAN NAME:_____ **RELATIONSHIP:**_____

EMPLOYER:_____ **OCCUPATION:**_____

EMPLOYER ADDRESS:_____

BILLING INFORMATION (IF DIFFERENT THAN ABOVE)_____

EMAIL ADDRESS: _____

NAME OF EMERGENCY CONTACT:_____

RELATIONSHIP_____ **TELEPHONE #: (_____)**_____

PLEASE LIST ONLY THE PHONE NUMBERS THAT WE MAY CONTACT YOU:

HOME (_____)_____ **WORK (_____)**_____ **EXT**_____

CELL (_____)_____ **OTHER (_____)**_____ **SPECIFY**_____

PERMISSION FOR PHOTOGRAPHS

I hereby acknowledge that I have been advised that photographs are to be taken of my body under such conditions and at such times as may be approved by Dr. Christopher Marek. These photographs together with details regarding medical services rendered to me, may be used by Dr. Christopher Marek for medical information purposes. I grant this consent as a voluntary contribution In the interest of medical education and my consent is subject only to the conditions that I not be identified by name at any time during use or publication by Dr. Christopher Marek.

_____ _____
PATIENT OR GUARDIAN SIGNATURE **DATE**

_____ _____
WITNESS **DATE**

CONFIDENTIAL HEALTH QUESTIONNAIRE

NAME: _____ DATE: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____ HOW LONG AT CURRENT WEIGHT? _____

PLEASE SPECIFY NUMBER OF POUNDS IN PAST 12 MONTHS ☐ LOST ☐ GAINED _____

NAME OF FAMILY MD: _____ DATE OF LAST PHYSICAL: _____

DATE OF LAST EKG: _____ ☐ NORMAL ☐ ABNORMAL _____

DATE OF LAST CHEST XRAY: _____ ☐ NORMAL ☐ ABNORMAL _____

DATE OF LAST MAMMOGRAM: _____ ☐ NORMAL ☐ ABNORMAL _____

DO YOU USE TOBACCO? ☐ NO ☐ YES, HOW MANY PACKS/DAY? _____ HOW MANY YEARS? _____

DO YOU DRINK ALCOHOL? ☐ NO ☐ YES, HOW MANY DRINKS/DAY? _____ DRINKS/WEEK? _____

HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST 4 WEEKS? (CHECK ALL THAT APPLY)

☐ ASPIRIN ☐ IBUPROFEN (ADVIL, MOTRIN, ETC.) ☐ TYLENOL ☐ BLOOD THINNERS

FEMALES: DATE OF LAST MENSTRUAL PERIOD: _____ ☐ REGULAR ☐ IRREGULAR

NUMBER OF PREGNANCIES: _____ NUMBER OF LIVE BIRTHS: _____ C-SECTION ☐ YES ☐ NO

MALES: DO YOU DO TESTICULAR SELF EXAMS REGULARLY ☐ NO ☐ YES

HAVE YOU USED VIAGRA, LEVITRA, CIALIS WITHIN PAST 6 MONTHS ☐ NO ☐ YES, LAST USED _____

LIST ALL CURRENT MEDICATIONS: (ATTACH LIST IF NECESSARY)

MEDICATION & DOSAGE	PRESCRIBED BY	HOW LONG TAKEN	REASON

PREFERRED PHARMACY _____ TELEPHONE NUMBER (_____) _____

LIST ALL VITAMINS, DIET PILLS, & HERBAL SUPPLEMENTS TAKEN IN THE PAST 3 MONTHS _____

_____

DRUG ALLERGIES (LIST MEDICATION & TYPE OF REACTION) _____

_____

LIST ALL PRIOR SURGICAL HISTORY:

OPERATION	YEAR	MD	HOSPITAL	COMPLICATIONS

PLEASE CHECK ALL THAT APPLY

PATIENT NAME: _____

- [ ] DOES YOUR RELIGION PROHIBIT BLOOD TRANSFUSIONS?
- [ ] DO YOU TEND TO HEAL SLOWLY?
- [ ] DO YOU FORM LARGE SCARS OR KELOIDS?
- [ ] HAVE YOU EVER HAD HEPATITIS?
- [ ] HAVE YOU EVER HAD AN ADVERSE REACTION TO EPINEPHRINE?
- [ ] ARE YOU SENSATIVE TO ADHESIVE TAPE OR SUTURE MATERIAL?
- [ ] HAVE YOU RECENTLY TAKEN CORTISONE, ACTH, PREDNISONE, OR OTHER STEROIDS?
- [ ] ARE YOU ARE HIGH RISK OF EXPOSURE TO THE AIDS VIRUS (LIFESTYLE, HEALTHCARE WORKER, ETC)?

FAMILY HISTORY (PLEASE INDICATE IF A CLOSE RELATIVE HAS HAD ANY OF THE FOLLOWING & LIST RELATIVE)

- [ ] CANCER _____
- [ ] HEART ATTACK _____
- [ ] LUNG DISEASE _____
- [ ] DIABETES _____
- [ ] HIGH BLOOD PRESSURE _____
- [ ] NEUROLOGIC DISORDER _____
- [ ] KIDNEY DISEASE _____
- [ ] REACTION TO ANESTHESIA _____
- [ ] OTHER _____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING: (IF SO PLEASE PROVIDE DETAILS/DATES)

- [ ] ASTHMA _____
- [ ] ULCERS OR REFLUX _____
- [ ] CANCER _____
- [ ] CHEST PAIN/ANGINA _____
- [ ] DIABETES _____
- [ ] THYROID DISEASE _____
- [ ] SLEEP APNEA _____
- [ ] STROKE/"MINI-STROKE" _____
- [ ] MENTAL ILLNESS _____
- [ ] BLOOD CLOTS/BLEEDING DISORDER _____
- [ ] HEART ATTACK/FAILURE _____
- [ ] IRREGULAR HEART RATE _____
- [ ] HIGH BLOOD PRESSURE _____
- [ ] GLAUCOMA _____
- [ ] SPINA BIFIDA _____
- [ ] OTHER _____

LATEX ALLERGY SCREENING: (CHECK ALL THAT APPLY)

HAVE YOU EVER HAD AN ALLERGIC REACTION ASSOCIATED WITH ANY OF THE FOLLOWING? IF SO, LIST DETAILS AS TO TYPE OF REACTION AND DATE.

- [ ] **NO LATEX ALLERGY**

- [ ] RUBBER GLOVES
- [ ] POWER FROM RUBBER GLOVES
- [ ] BALLOONS
- [ ] CONDOMS
- [ ] RUBBER/LATEX

DETAILS: _____

HAVE YOU HAD ANY OF THE FOLLOWING IN THE PAST 3 MONTHS (CHECK ALL APPLY)

- [ ] ANXIETY
- [ ] ASTHMA
- [ ] BLOOD IN STOOL
- [ ] BRONCHITIS
- [ ] CHEST PAIN
- [ ] CONSTIPATION
- [ ] COUGH
- [ ] DEPRESSION
- [ ] DIFFICULTY SLEEPING
- [ ] DRY EYES
- [ ] EASY BRUISING
- [ ] EXCESSIVE BLEEDING
- [ ] FAINTING
- [ ] FATIGUE
- [ ] FEVER
- [ ] FEVER BLISTERS
- [ ] FREQUENT URINATION
- [ ] HAIR LOSS
- [ ] HEADACHE
- [ ] HOARSENESS
- [ ] JAUNDICE
- [ ] JOINT PAIN
- [ ] NAUSEA
- [ ] NIGHT SWEATS
- [ ] NUMBNESS
- [ ] PNEUMONIA
- [ ] RASHES
- [ ] SEIZURES
- [ ] SHORTNESS OF BREATH
- [ ] SKIN CHANGES
- [ ] WATERY EYES
- [ ] WEAKNESS

Central Kentucky Plastic Surgery

Dr. Christopher Marek
Board Certified Plastic Surgeon

Privacy Consent for Use or Disclosure of Patient Information for the Purposes of Treatment, Payment and Healthcare Operations

I hereby consent to Central Kentucky Plastic Surgery, PLLC using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for healthcare services rendered to me or to carry out the Practice's healthcare operations. I also consent to Central Kentucky Plastic Surgery, PLLC using or disclosing my protected health information for treatment activities provided by another healthcare provider, as well as the payment activities conducted by another healthcare provider or entity. I further consent to the disclosure of my protected health information in order for another provider or healthcare entity to conduct healthcare operations including quality assessment and reviewing the competence of healthcare professionals.

I further acknowledge Central Kentucky Plastic Surgery, PLLC has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

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