Cabbabe Plastic Surgery

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Your Name ________________________________ Your Age ______ Today's Date _______________

Referring Doctor: ______________________ Referring friend (if applicable): _____________________

Name/phone # of your Primary Care Physician: ____

Please tell us how you heard about us (check all that apply):

- ❑ www.stl-psc.com (our practice website)
- ❑ Google search
- ❑ Instagram (@drsamercabbabe)
- ❑ Facebook page (Cabbabe Plastic Surgery)
- ❑ Facebook forum (please list which one): ____
- ❑ Billboard
- ❑ Realself.com
- ❑ Breastimplantsbymentor.com (Mentor website)
- ❑ Itsmyturn.com (Allergan website)
- ❑ Sientra.com (Sientra website)
- ❑ Yellow Pages

Name/Street/phone# of your pharmacy: ____

Reason for your visit today: ____

Check any/all areas you would like to discuss with Dr. Cabbabe below:

- ❑ Face
- ❑ Breast
- ❑ Abdomen
- ❑ Buttocks
- ❑ Hips/Thighs
- ❑ Back
- ❑ Arms

Do you have or have you ever had any health problems, which required treatment? (circle Y/N)

Y N Anemia (indicate if still an active problem) ______________________________________

Y N Bleeding problems ____

Y N Blood clots ____

Y N Heart trouble or heart attacks ____

Y N High blood pressure ____

Y N Stroke ____

Y N Paralysis ____

Y N Lung problems ____

Y N Emphysema ____

Y N Thyroid problems ____

Y N Hepatitis ____

Y N Kidney trouble ____

Y N HIV or AIDS ____

Y N Diabetes (list HBA1C if known) ____

Y N Female problems ____

Y N Breast Cancer ____

Y N Cancer, Type of cancer: ____

Y N MRSA or other Staph Infections ____

Y N Tuberculosis Active____ Inactive_____ Diagnosis date_______

Please list any prior surgeries:

Surgery (**if applicable, please indicate Left or Right**) Date Physician Hospital

____
____
____
____
____
____
____
____
____

Please list all current medications or provide us with your list so we may photocopy it:
Medicine Dose Frequency

____
____
____
____
____
____
____
____
____

Do you have any drug allergies? yes no If yes, check below and list reaction(s):

- ❑ Latex Reaction(s): ____
- ❑ penicillin Reaction(s): ____
- ❑ sulfa Reaction(s): ____
- ❑ "mycin" Reaction(s): ____
- ❑ aspirin Reaction(s): ____
- ❑ codeine Reaction(s): ____
- ❑ tetanus Reaction(s): ____
- ❑ adhesives Reaction(s) :____
- ❑ other medications & reaction(s): ____

Do you smoke currently? no yes
In the past? no yes If yes, how much (per day)?______________________

Do you use either of the following products? ___electronic cigarettes ___ chewing tobacco
If yes, how many/how often (per day)? ________________

Do you use alcohol currently? no occasionally daily
In the past? no yes

Do you exercise? no occasionally regularly

Do you have any other special needs of which we should be aware? no yes
If yes, please describe? ____

What type of work do you do? ____

Has any blood relative ever had any of the following conditions? If yes, please check below and indicate relationship (i.e. Mother, brother). If applicable, please indicate if relative is maternal

(mother's side) or paternal (father's side) relative:

- ❑ **NONE**
- ❑ Seizures Relative(s): ______________________________
- ❑ Cancer Relative(s): ______________________________
- ❑ Breast Cancer Relative(s): ______________________________
- ❑ Tuberculosis Relative(s): ______________________________
- ❑ Diabetes Relative(s): ______________________________
- ❑ Heart trouble Relative(s): ______________________________
- ❑ High blood pressure Relative(s): ______________________________
- ❑ Stroke Relative(s): ______________________________
- ❑ Mental illness Relative(s): ______________________________
- ❑ Suicide Relative(s): ______________________________
- ❑ Birth defects Relative(s): ______________________________
- ❑ Kidney troubles Relative(s): ______________________________
- ❑ Kidney stones Relative(s): ______________________________
- ❑ Bladder Relative(s): ______________________________
- ❑ Any heritable disease Relative(s): ______________________________

Have you had pneumonia vaccine? ___No ___Yes Year of last vaccination: _____________

Have you had a COVID vaccine? ___No ___ Yes Did you receive a booster? ___No ____Yes

Date of last colonoscopy: _____________________

Females only: Date of your last Pap smear: _________________

Females only: Have you had a mammogram? __No __Yes Date of last mammogram:___________

Currently are you experiencing any of the following symptoms? If yes please check below:

- ❑ **NONE**
- ❑ Severe headaches
- ❑ Ringing in the ears
- ❑ Dizziness
- ❑ Fainting spells
- ❑ Blind spells
- ❑ Chest pain
- ❑ Breast pain, discharge or masses
- ❑ Spitting up blood
- ❑ Chronic cough
- ❑ Shortness of breath
- ❑ Fever
- ❑ Severe indigestion
- ❑ Jaundice
- ❑ Diarrhea
- ❑ Rectal bleeding
- ❑ Bleeding tendencies

What is your current height _____________ and weight _______________

Any recent changes? ____