



Bitar Cosmetic Surgery Institute

George J. Bitar, M.D., FACS, Medical Director

Board Certified Plastic Surgeon
Cosmetic & Reconstructive Plastic Surgery

Today's Date: _____

Male _____ Female _____

Name: _____
Last First Middle Preferred name

Date of Birth: ____/____/____ Age ____ Social Security #: _____

Address: _____ City: _____ State: _____

Zip Code: _____ email address: _____
(by listing you give us consent to contact you via email)

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

What number would you like us to reach you? _____

Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Employer _____ Occupation? _____

Employer's Address _____

Name of primary care physician: _____ Phone number: (____) _____

How did you hear about us?

- | | |
|--|--|
| <input type="checkbox"/> Doctor Referral – name _____ | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Friend/Relative – name _____ | <input type="checkbox"/> www.DrBitar.com |
| <input type="checkbox"/> Magazine | <input type="checkbox"/> YourPlasticSurgeryGuide.com |
| <input type="checkbox"/> <i>Washingtonian</i> Magazine | <input type="checkbox"/> BreastImplants411.com |
| <input type="checkbox"/> <i>Your Health</i> Magazine | <input type="checkbox"/> BreastImplantsUSA.com |
| <input type="checkbox"/> <i>Washingtonian</i> Magazine Online | <input type="checkbox"/> ObesityHelp.com |
| <input type="checkbox"/> Yellow Pages – of which region? _____ | <input type="checkbox"/> LoveYourLook.com |
| <input type="checkbox"/> Other (please specify): _____ | <input type="checkbox"/> Liposuction.com |

LiquidFacelift.com

Google

Yahoo

MSN

Search engine words: _____

What would you like to discuss with Dr. Bitar?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Facial Rejuvenation | <input type="checkbox"/> Breast Procedures | <input type="checkbox"/> Body Contouring | <input type="checkbox"/> What would you like to discuss with our Estheticians? |
| <input type="checkbox"/> Chin Implant | <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Abdominal Etching (6pk) | <input type="checkbox"/> Customized Facials |
| <input type="checkbox"/> Corrugator Muscle Excision | <input type="checkbox"/> Breast Lift | <input type="checkbox"/> Abdominoplasty | <input type="checkbox"/> Skin Care |
| <input type="checkbox"/> Dermabrasion | <input type="checkbox"/> Breast Lift w/Augmentation | <input type="checkbox"/> Arm Lift | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Ear Pinning (Otoplasty) | <input type="checkbox"/> Breast Implant Removal | <input type="checkbox"/> Brazilian Butt Lift | <input type="checkbox"/> IPL |
| <input type="checkbox"/> Eyelid Lifts | <input type="checkbox"/> Breast Implant Exchange | <input type="checkbox"/> Labiaplasty | |
| <input type="checkbox"/> Facelift | <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Liposuction – Laser | |
| <input type="checkbox"/> Fat Grafting | <input type="checkbox"/> Gynecomastia Reduction | <input type="checkbox"/> Liposuction – Tumescant | |
| <input type="checkbox"/> Forehead Lift | <input type="checkbox"/> Nipple/Areola Reduction | <input type="checkbox"/> Lower Body Lift | |
| <input type="checkbox"/> Mole/Cyst Removal | | <input type="checkbox"/> Mole/Cyst Excision | |
| <input type="checkbox"/> Neck Lift | | <input type="checkbox"/> Scar Revision | |
| <input type="checkbox"/> Rhinoplasty | | <input type="checkbox"/> Thigh Lift | |
| <input type="checkbox"/> Other: _____ | | | |

My time frame for surgery is:

As soon as possible 1-3 months from now 6-12 months from now Just need information

Emergency Contact (nearest relative or neighbor not living with you):

Name: _____ Phone number: (_____) _____ Relationship: _____

Do you have any medical problems? Please list any past history of serious illnesses, current or chronic conditions?

Please list any previous surgeries, and their dates, including any cosmetic surgeries, which you have had:

Do you have any drug allergies/sensitivities? If so please describe symptoms: _____

Any allergy/reaction to Tetanus shots/boosters in the past? _____

Are you allergic to anesthesia? _____

Are you allergic to latex, tape? _____

Do you have any bleeding tendencies? _____

Do you smoke? _____ Pack(s)/day? _____ Number of years? _____

Do you drink alcohol? Yes _____ No _____ How much? _____

Please list all medications you are currently taking:

	Name	Dosage	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

FOR WOMEN ONLY

Are you pregnant? Yes _____ No _____ Unsure _____

Please Note: You cannot have surgery if you are pregnant! Please inform us if you are pregnant!

Birth control method used _____ Number of pregnancies _____

Type of delivery? _____ Number of Children _____ Ages of children? _____

Last Mammogram Date _____ / _____ / _____ Have you ever had breast cancer? Yes _____ No _____

Have you ever had cervical cancer? Yes _____ No _____ ovarian cancer? Yes _____ No _____

Do you presently have or have you ever experienced any of the following (please check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Aids | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy or Seizure history |
| <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fever Blisters |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney Problems |

I authorize release of any information to physicians, nurses, medical students, and other health care personnel who provide you with health care services or are involved in your care. For example, if you are being scheduled for surgery, we may disclose your medical information to a surgical scheduler at the hospital in order to coordinate your care.

Signature of Patient or Guardian

Date