



# 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?

- Doctor Referral – name \_\_\_\_\_
- Friend/Relative – name \_\_\_\_\_
- Magazine
  - American Airlines Magazine
  - Delta Airlines Magazine
  - Hemispheres (United Airlines)
  - Washingtonian Magazine
  - Washingtonian Magazine Online
  - Your Health Magazine
- Yellow Pages – of which region? \_\_\_\_\_
- Internet
  - YourPlasticSurgeryGuide.com
  - BreastImplants411.com
  - BreastImplantsUSA.com
  - ObesityHelp.com
  - LoveYourLook.com
  - Search engine words: \_\_\_\_\_
  - Other (please specify): \_\_\_\_\_
- Liposuction.com
- LiquidFacelift.com
- Google
- Yahoo
- BING

### What would you like to discuss with Dr. Bitar?

- Facial Rejuvenation**
  - Botox/ Dysport
  - Chin Implant
  - Dermabrasion
  - Ear Pinning (Otoplasty)
  - Eyelid Lifts
  - Facelift
  - Fat Grafting
  - Fillers
  - Forehead Lift
  - Laser Skin Resurfacing
  - Mole/Cyst Removal
  - Neck Lift
  - Rhinoplasty
  - Other: \_\_\_\_\_
- Breast Procedures**
  - Breast Augmentation
  - Breast Lift
  - Breast Lift w/Augmentation
  - Breast Implant Removal
  - Breast Implant Exchange
  - Breast Reduction
  - Gynecomastia Reduction
  - Nipple/Areola Reduction
- Body Contouring**
  - Abdominal Etching (ópk)
  - Abdominoplasty
  - Arm Lift
  - Brazilian Butt Lift
  - Labiaplasty
  - Liposuction – Laser
  - Liposuction – Tumescant
  - Lower Body Lift
  - Mole/Cyst Excision
  - Scar Revision
  - Thigh Lift

### What would you like to discuss with our Estheticians?

- Acne Treatments
- Chemical Peels
- Customized Facials
- Fine Wrinkle Reduction Treatments
- IPL/Photofacials
- Microdermabrasion
- Rosacea Treatments

**My time frame for surgery is:**

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

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

Name: \_\_\_\_\_ Phone number: ( \_\_\_\_\_ ) \_\_\_\_\_ Relationship: \_\_\_\_\_

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

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

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

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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? \_\_\_\_\_

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**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 \_\_\_\_\_

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**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             |

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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.

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Signature of Patient or Guardian

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Date