PLASTIC SURGERY CENTER OF TAMPA
JAIME PEREZ, M.D., FACS AND TRACI M TEMMEN, M.D.
Plastic & Reconstructive Surgery
307 S Macdill Ave.
TAMPA, FL 33609
PHONE: (813)877-3739 FAX (813)877-3738

PATIENT INFORMATION SHEET

Date: ____________________

Last Name ____________________ First Name ____________________ MI __________

SSN# _____-_____-_____ DOB ___/___/____ Age _____ Sex _____ Relationship Status __________

Home Address

____

City ____________________ State ____________ ZIP ____________

Home Phone ______________ Work ______________ Cell ______________

Occupation ______________ Employer/School ____________________

E-mail address

____

Reason for visit? ____

Who referred you or how did you find out about us? ____________________

Health Insurance Company ____________________ Policy # ____________________

SPOUSE/PARENT/SIGNIFICANT OTHER

Last Name ______________ First Name ______________ Relationship ______________

Address ____

City ____________________ State ____________ ZIP ____________

Home ______________ Work ______________ Cell ______________

EMERGENCY CONTACT(s)

☐ Same as above

1) Name ____________________________ Relationship ______________

Home ______________ Work ______________ Cell ______________

2) Name ____________________________ Relationship ______________

Home ______________ Work ______________ Cell ______________

Signature ____________________ Date ____________________

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Traci M Temmen, M.D

PATIENT MEDICAL HISTORY

Patient Name: ____________________ Age: _____ Sex: _____ Height: ______ Weight: _____

Drug Allergies: ____________________ Date of last Tetanus: ____________________

List all medications taken on a regular basis: (Please include over the counter medications current prescriptions)

____

Do you smoke: ☐ YES ☐ NO Amount/Type: __________ Alcohol: ☐ YES ☐ NO Amount: ______

Please list all medical problems and past surgeries: (Please include year of surgery)

____

Have you ever had any complications with general anesthesia? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO ☐ UNKNOWN Date of your last menstrual period __________

Year of last Mammogram __________

Do you have children? ☐ YES ☐ NO If so how many? ______ Ages __________

PLEASE CHECK AND DATE ALL THAT APPLY

✓		✓		✓	
	ADRENAL DISEASE		DIABETES		MUSCLE WEAKNESS
	ANEMIA		DIFFICULTY SWALLOWING		NASAL OBSTRUCTION
	ARTHRITIS		DIZZINESS		NAUSEA / VOMITING
	ASTHMA		DIVERTICULITIS		NERVE INJURY
	BACK PAIN		EMPHYSEMA		PACE MAKER
	BLADDER INFECTIONS		EPILEPSY / SEIZURES		PERSISTENT HOARSENESS
	BLEEDING TENDENCIES		EYE OR VISION PROBLEMS		PITUITARY DISEASE
	BLOOD DISEASE		GALL BLADDER DISEASE		PNEUMONIA
	BLOOD IN STOOL		GLAUCOMA		PROSTATE PROBLEMS
	BLOOD IN URINE		HEADACHES		RHEUMATIC FEVER
	BLOOD PRESSURE (HIGH)		HEARING PROBLEMS		SEVERE NERVOUSNESS
	BLOOD PRESSURE (LOW)		HEART DISEASE		SHORTNESS OF BREATH
	BREAST PROBLEMS		HEPATITIS		SINUSITIS
	BROKEN BONES		HERNIA		STROKE
	BRONCHITIS		HIVES / RASH		SWOLLEN LYMPH NODES
	CANCER		HIV/AIDS		THYROID / GOITERS
	CHEST PAIN		JOINT PAIN		WEIGHT GAIN (RAPID)
	CHRONIC COUGH		KIDNEY DISEASE		WEIGHT LOSS (RAPID)
	CIRRHOSIS		MENTAL DEPRESSION		IRREGULAR HEARTBEAT
	CONSTIPATION		MISCARRIAGES		OTHER
	CYSTS		MONONUCLEOSIS		

______________________________ ______________________________
Patient's Signature (or Parent, if patient is a minor Date

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PATIENT RECORD OF DISCLOSURES

Patient Name: ______________________________ Date: ________________

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. *(PHI)* The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence the individuals office instead of the individuals home.

Plastic Surgery Center of Tampa typically communicates with their patient's by telephone. If you do not approve of this method or have an alternate manner of communication, please provide us with this information by completing the following"

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at the Plastic Surgery Center of Tampa.

(Check all that apply):

VERBAL COMMUNICATIONS

Home Telephone: ________________________

- ☐ Speak only to patient
- ☐ Leave a detailed message on answering machine
- ☐ Leave call back number only

Work Number: ________________________

- ☐ Speak only to patient
- ☐ Leave a detailed message on answering machine
- ☐ Leave call back number only

WRITTEN COMMUNICATIONS

☐ O.K to mail to home address: ____

☐ O.K to mail to work address: ____

Please list any other restrictions regarding messages or reminders about your healthcare or account:

Please list below any other persons authorized to discuss your account.

____

____

Patient signature: ______________________________

Plastic Surgery Center of Tampa
Patient Bill of Rights

Section 381.026, Florida Statutes, addresses the Patient's Bill of Rights and Responsibilities. The purpose of this section is to promote the interests and well being of patients and to promote better communication between the patient and the health care provider. Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows.

A patient has the right to:

Be treated with courtesy and respect, with appreciation of his or her dignity, and with protection of privacy.

Receive a prompt and reasonable response to questions and requests.

Know who is providing medical services and who is responsible for his or her care.

Know what patient support services are available, including if an interpreter is available if the patient does not speak English.

Know what rules and regulations apply to his or her conduct.

Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.

Refuse any treatment, except as otherwise provided by law.

Be given full information and necessary counseling on the availability of known financial resources for care.

Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare.

Receive prior to treatment, a reasonable estimate of charges for medical care.

Receive a copy of an understandable itemized bill and, if requested, to have the charges explained.

Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such research.

Express complaints regarding any violation of his or her rights.

A patient is responsible for:

Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his or her health.

Reporting unexpected changes in his or her condition to the health care provider.

Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.

Following the treatment plan recommended by the health care provider.

Keeping appointments and, when unable to do so, notifying the health care provider or facility.
His or her actions if treatment is refused or if the patient does not follow the health care provider's instructions.

Making sure financial responsibilities are carried out.

Following health care facility conduct rules and regulations.

I acknowledge that I have read and understand the Patient's Bill of Rights.

_______________________________ _______________________

Signature Date

Plastic Surgery Center of Tampa

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Traci M. Temmen, M.D.

Pre-Operative Questionnaire for Malignant Hyperthermia

1. Does patient have a family history of unexpected death(s) following general anesthesia?
   Yes No ____________
2. Has family or personal history of MH, a muscle or neuromuscular disorder?
   Yes No ____________
3. High temperature following exercise?
   Yes No ____________
4. Personal history of muscle spasm, dark or chocolate colored urine?
   Yes No ____________
5. Unanticipated fever immediately following anesthesia or serious exercise?
   Yes No ____________
6. History of blood clots or venous thrombosis?
   Yes No ____________

________________________________ ________________

Patient's Signature (or Parent, if patient is a minor) Date

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Pre-Operative Questionnaire for Bleeding and /or Clotting Disorders

BLEEDING DISORDERS:

1. Do you have a history of unexplained bleeding or easy bruising causing you to seek medical treatment before? Yes No
2. Do you have a history of chronic anemia? Yes No
3. Have you had weight-loss surgery in the past? Yes No
4. Have you or your doctors ever had difficulty getting bleeding to stop after dental work, minor injuries, or surgeries? Yes No
5. Do you or a family member have a history of hemophelia? Yes No

CLOTTING DISORDERS:

1. Have you had recent elective hip or knee joint replacement surgery? Yes No (5)
2. Have you had a broken hip, pelvis, or leg in the last month? Yes No (5)
3. Have you had a serious trauma (e.g. car accident, broken bone, major fall) within the last month? Yes No (5)
4. Have you had a spinal cord injury or paralysis in the last month? Yes No (5)
5. Have you ever had a blood clot in your legs or lungs? Yes No (3)
6. Do you have a family history of blood clots in the veins, legs, or lungs? Yes No (3)
7. Do you have a family history of blood-clotting disorders? Yes No (3)
8. Have you had more than three days of continuous bed rest due to injury or illness in the past month? Yes No (2)
9. Have you had a catheter or tube in your neck or chest that delivers blood or medicine directly to the heart (also called central venous access) within the last month? Yes No (2)
10. Have you had a broken limb that required a cast in the past month? Yes No (2)
11. Have you had a major surgery lasting more than an hour in the last month? Yes No (2)
12. Do you have or have you ever been diagnosed with cancer? Yes No (2)
13. Do you have leg swelling every day? Yes No (1)
14. Do you have visible varicose veins or spider veins? Yes No (1)

15. Do you have inflammatory bowel disease? Yes No (1)

16. Do you have emphysema or COPD? Yes No (1)

17. Have you had a heart attack or heart failure? Yes No (1)

18. Have you had a serious infection (e.g. pneumonia or kidney infection) in the last month? Yes No (1)

19. Are you overweight, obese, or weight over 250 lbs? Yes No (1)

20. What is your age? Circle One:

Under 40 41-59 (1pt) 60-74 (2pts) 75 and over (3pts)

For Women Only:

21. Do you use birth control pills or estrogen therapy? Yes No (1)

22. Are you pregnant or have you had a baby within the last month? Yes No (1)

23. Do you or a family member have a history of multiple unexplained miscarriages Yes No (1)

Clotting Disorders Total Score:________________

(Add all points for a "yes" answers and age group.)

Score	Risk Assessment	Recommended Prophylaxis Regimen*
0 to 2	Very Low to Low	Early ambulation and/or SCD's during surgery
3 to 5	Moderate to High	Early ambulation, SCD's during surgery, and prophylactic Lovenox given in surgery then continued until ambulating well.

Your Risk Assessment is:__________________

(Very Low to Low -OR- Moderate to High)

______________________________ ________________

Patient's Signature (or Parent, if patient is a minor) Date

* This is a general guideline, not a guarantee of appropriate risk stratification, prevention, and/or proper treatment. Always discuss clotting disorder risk assessment and prophylaxis/treatment recommendations with your doctor.

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How long have you been considering this procedure?

____

When are you planning to have your procedure performed?

____

Are you interested in learning about financing options during your consult?

____

Do you smoke? ______________ If so, How many per day, for how long, and are you willing to refrain from smoking if recommended by the doctor prior to your procedure?

____

Do you have any particular questions we could answer for you in reference to your desired procedure?

____

____

____

An overview of your visit today:

You will meet with a consultant first to get familiar with the office and inform you about the doctor and desired procedure, after which you will be presented with pictures of patients that have had similar procedures performed. You will meet the doctor and have the opportunity to ask more questions and will be examined shortly afterwards. After your examination you will come into another room where, after which prices will be discussed.