

Patient Data Sheet

Privacy act statement: AUTHORITY: Title 5, Section 301, Title 10, USC Section 1071

PRINCIPAL PURPOSES: This information is to aid the physicians in the identification, evaluation and treatment of the patient.

ROUTINE USES: Information is stored in office files for identification of the patient and gives pertinent medical information of the condition until patient's departure to CONUS.

NAME _____ DATE OF BIRTH _____ SEX _____
 LAST FIRST MI

MARRIED? YES NO SPOUSE/SO CURRENTLY HOME? YES NO

CHILDREN? YES NO NUMBER OF CHILDREN: _____ AGES: _____

STATUS: DEPENDENT RETIREE ACTIVE DUTY

SERVICE: ARMY AF NAVY CIVILIAN

RANK OF SPONSOR _____ SPONSOR SSN: _____-_____-_____

DUTY LOCATION: _____ DEROS DATE: _____

MAILING ADDRESS _____ BOX # _____

APO _____ EMAIL ADDRESS _____

CELL PHONE# _____ DUTY PHONE (DSN) _____

WHERE YOUR MEDICAL RECORDS ARE KEPT: _____

MOS/AFCS JOB DESCRIPTION: _____
(PLAIN ENGLISH)

DEPARTMENT OF PLASTIC AND RECONSTRUCTIVE SURGERY

LANDSTHUL REGIONAL MEDICAL CENTER

Consent for Taking and Use of Still and Digital Photographs, Still and Moving Video Images and Computer Images. Requested by
Bradford Scanlan, DO FACS, MAJ (P). MC, USA

Patient Name (please print) _____ DOB: _____

Sponsor Rank: _____ Sponsor FMP/Social Security Number: _____/_____-_____-_____

I hereby certify that I am the Patient OR Legal Guardians of the above named patient, and consent that still and digital Photographs, moving video, images and/or computer imaging may be taken of the above named patient or parts of the patient's body under the following conditions and used under the following reasons:

1. The photographs, Moving video imaging and/or computer may be taken at the consent of the above named physician or photographer approved by that physician.
2. I, the named patient or the patient's legal guardian authorizes the use of photographs, video images. and/or computer images taken of the patient for the following educational and/or scientific purposes, The patient or guardian may specifically disallow use of any and all patient images for a particular purpose by drawing a line through the specific proposed use and writing his/her initials beside that line of text. The named physician will also initial those specified objections:
 - a. Lectures and presentations for an audience of medical professionals or for the general public
 - b. Medical, surgical and scientific articles or books authored by the above named physicians and/or other persons authorized by the named physician:
 - c. Selected newspaper and magazine articles, as well as television programs, authorized by the named physician:
 - d. Patient education materials for the named physician office use;
 - e. Patient/physician education through internet use by the named physician:
 - f. Any other purpose which may be deemed proper by the named physician above, and exclusively by the named physician in the interest of medical education, knowledge or research:
3. I the patient, or legal guardian of the patient object specifically to the public use of photographs, videos images and/or computer images of this/these specific body area(s): _____
4. I understand that all photographs, video images and/or computer images viewed of the patient are demonstrative in purpose and are only a representation of a possible result that could be achieved through the proposed surgery. I further understand that imaging is used as an educational tool to benefit the patient and does not guarantee any result.
5. I understand that the patient will not be identified by name. I understand that such photographs, video images may reveal my identity to others. I accept this potential loss of anonymity.
6. This authorization is granted in order to further medical education, Knowledge, research or the general public welfare and as a voluntary contribution. I/we hereby waive all rights I/we might have to such photographs, video images and/or computer images and do hereby release, discharge and save harmless the above named physicians and any and all employees and agents from all claims, liabilities whatsoever in law and in equity arising from such use.
7. I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case for use in examination, testing credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

Patient/Legal Guardian Signature: _____ Date signed: _____

Relationship to Patient, if legal Guardian signing: _____

Witness name, rank and signature: _____

Plastic and Reconstructive Surgery Initial Clinic Visit Form

Landstuhl Regional Medical Center

(PLEASE PRINT LEGIBLY)

AUTHORITY: Title 5, Section 301, Title 10 USC Section 1071.
 Principal Purpose: This information is to aid the physician in the identification evaluation and treatment of the patient.
 Routine Uses: Information is stored in office files for identification of the patient and gives pertinent medical information of the condition until departure to CONUS of the patient.

Patient Name: Date:

Sponsor FMP/SSN: .../..... Date of Birth:

Service: Army AF Navy CIV. Email:

Do you want to receive material information by email? Yes No

What is your reason for seeing Dr Scanlan? Check all that apply

- | | | |
|---|--|--|
| <input type="checkbox"/> Abdominoplasty | <input type="checkbox"/> Browlift | <input type="checkbox"/> Chin Augmentation |
| <input type="checkbox"/> Arthritis Surgical Pain | <input type="checkbox"/> Hand Mass/Tumor | <input type="checkbox"/> Skin Lesion/cancer |
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Facial bone reconstruction | <input type="checkbox"/> Liposuction |
| <input type="checkbox"/> Carpal tunnel Syndrome | <input type="checkbox"/> Cervical Z-Plasty (neck waddle) | <input type="checkbox"/> Soft tissue contour defect |
| <input type="checkbox"/> Breast Reconstruction | <input type="checkbox"/> Nail Injury | <input type="checkbox"/> Otoplasty |
| <input type="checkbox"/> Body contouring (surgical) | <input type="checkbox"/> Hemangioma /congenital lesion | <input type="checkbox"/> Ventral hernia |
| <input type="checkbox"/> Cubital Tunnel Syndrome | <input type="checkbox"/> Chemical Peel | <input type="checkbox"/> Rhinoplasty |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Some Nerve Syndrome | <input type="checkbox"/> Wound management |
| <input type="checkbox"/> Botox | <input type="checkbox"/> Panniculectomy | <input type="checkbox"/> Septoplasty |
| <input type="checkbox"/> Duputryens | <input type="checkbox"/> Face lift/ Neck Lift | <input type="checkbox"/> Soft Tissue Fillers |
| <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Tendon problem | <input type="checkbox"/> Body contouring after massive weight loss |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Scar/deformity | <input type="checkbox"/> Other..... |
| <input type="checkbox"/> Ganglion Cyst | <input type="checkbox"/> Facial bone Reconstruction | <input type="checkbox"/> Septo/Rhinoplasty |
| <input type="checkbox"/> Congenital birthmark | <input type="checkbox"/> Traumatic Hand | |

Don't see it? Don't know where it should go? Write it here.....

Medical History

Yes	No	Do you have.....	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	Heart Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmurs	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitation	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Ankles
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Is your general health good
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Any other serious illness? List
<input type="checkbox"/>	<input type="checkbox"/>	Chronic lung or bronchial disease		
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems		
<input type="checkbox"/>	<input type="checkbox"/>	Asthma		
<input type="checkbox"/>	<input type="checkbox"/>	Anemia		
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder		
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes		
<input type="checkbox"/>	<input type="checkbox"/>	Cancer		
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems		
<input type="checkbox"/>	<input type="checkbox"/>	Do any disease run in your family? List.....		

What is your HT..... Weight.....lbs
 Known Best Guess

Have you ever had a psychiatric problems, nervous breakdown or been under the care of a psychiatrist, psychologist or therapist?

Explain:
 Date of last physical exam:..... I am right left hand dominant
 FOR FEMALE: Date of Last period..... Pap smear:..... Breast Exam:.....
 Any problems or concern with any of the above? Yes No (Explain)

**Plastic and Reconstructive Surgery Clinic
Landstuhl Regional Medical Center
STATEMENT OF UNDERSTANDING**

Please initial where indicated and sign at the bottom.

Smoking, Second-Hand Smoke Exposure, Nicotine Products (Patch, Gum, Nasal Spray)

Patients who are currently smoking, use tobacco, products or nicotine products patch gum nasal spray are at a greater risk for significant surgical complications of skin dying delayed healing and additional scarring. Most individuals exposed to second-hand smoking are also at potential risks for similar complications attributable to anesthesia with coughing and possible increased bleeding. Individuals who are not exposed to tobacco or nicotine containing products have a significantly lower risk of this type of complication. Please indicate current status regarding these items below.

_____ I am a non-smoker and do not use nicotine products; I understand the risk of second-hand smoke causing surgical complications.

_____ I am a smoker or use tobacco/nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.

_____ I understand that it is important to refrain from smoking at least 6 weeks before surgery and until your physician states it is safe to return, if desired.

GUARANTEES

_____ I understand that the only guarantee that I will receive is that Dr Scanlan will do his best to give me the most optimal result. I understand that there are no other guarantees expressed or implied about my surgery.

_____ I understand that my surgery can be cancelled at any time and there are no guarantees that it can be rescheduled

_____ I understand that everyone heals differently and that my final result may not be that described to me shown to me on a computer for these surgeries.

_____ I understand that additional surgeries may be necessary to achieve the desired result and there may be additional expenditures for these surgeries.

SUN SCREEN/SUN BLOCK

_____ Surgical scars can become darker (or in dark pigmented patients-lighter) when exposed to the sun. Wearing sun screen/sun block on your incision everyday you go out (even if it is cloudy) is very important. Applying sunscreen is not necessary if your incision is hidden under clothing, but it is a good habit to practice to minimize your risks of skin cancer.

_____ I pledge to apply sun screen/ sun block to my surgical sites for a minimum of one year after my surgery.

TEAM EFFORT

_____ I understand that to achieve long lasting results after surgery two things must happen, first you must have a successful surgery and second you must maintain those results with a healthy lifestyle of good nutrition, exercise and remain tobacco free.

_____ I pledge to maintain a healthy lifestyle after surgery and understand that if I fail to do so, I may not enjoy lasting results from my surgery. I understand the importance of the pledges I have made.

.....
Patient or Person Authorized to sign for Patient (Print name and sign)

Date: Witness:

MEDICATIONS

Yes No Do you take.....

Prescription medication List Here:

Over the counter medication

Birth control

Herbal/Alternative medications

ALLERGIES

Are you allergic to or have you ever had a reaction to any medication, drug or local anesthetic?

Yes No Please list the drug and reaction you experienced:

PAST HOSPITALIZATIONS.

Please list any past hospitalizations in the table below.

Reason for Hospitalization	Name/location of Hospital	Date (Month/Year)

PAST SURGICAL HISTORY

Please list any past surgical history in the table below

Reason for Hospitalization	Name/location of Hospital	Date (Month/Year)

Please include all treatment such as laser, Liposuction, steroid injections or facial resurfacing procedures

BLEEDING/SCARRING/ANESTHESIA

Yes No Do you or a member of your family have difficulty with prolonged bleeding when cut

Yes No Do you or a member of your family bruise easily?

Yes No Do you have a problem with scarring or have you ever formed a keloid after being cut?

Yes No Have you or any member of your family ever had a problem with anesthesia?

Please explain any "Yes" answer: _____

SOCIAL HISTORY

Did you ever or do you currently smoke? Yes No If yes, how many years: _____ Number of packs per day _____ Date of last cigarette/cigar: _____ Do you use any nicotine product (gum, patch, spray) Yes No

Do you use any "smokeless" tobacco product (i.e. chew, snuff?) Yes No

Do you drink alcohol? Yes No If yes, what: Beer Wine Hard liquor Please list what and how much you consume per week (on average): _____

Do you use any non-prescription drugs? Yes No List: _____

How many hours of exercise (on average) per week do you get? Never/Rare 1-2 hrs 3-5 hrs >6 hrs

What do you do to exercise: run walk play sports gym aerobic machines other.