TAROLA PLASTIC SURGERY
NICHOLAS A. TAROLA, MD

**Nicholas A. Tarola, M.D.**
**1216 N. Maple Street, Suite 1**
**Murfreesboro, TN 37130**

Last Name_____First_____MI_____

Mailing Address (Street Name) _____

City_____ State_____Zip_____

Date of Birth: _____Age: _____ Sex: ____M ____F S.S. # _____ Height_____'_____" Weight_____lb

Marital Status S___M___D___W___ Spouse Name: _____

Telephone: Home _____ Cell_____Work_____

May we leave information on your answering machine or voice mail? ____Y ____N May we call you at work? ___Y ___N

**Email address:** _____May we contact you by email? ____ Y ____ N

How did you hear about our office?_____

Your Occupation:_____Employer:_____

Employer Address: _____

Emergency Contact Person_____Relationship_____

Telephone_____ **Pharmacy** _____

Primary Care Physician_____ Phone_____Fax_____

Address of Physician_____
City State Zip

Referring Physician_____ Phone: _____ Fax:_____
(if other than PCP above) First Last

Name of Primary Insurance_____Insurance Address_____

Policy Holder's
Name_____DOB_____Policy#_____Group#_____

Secondary Insurance_____Insurance Address_____

Policy Holder's
Name_____DOB_____Policy#_____Group#_____

*I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly to Tarola Plastic Surgery, PLLC. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent.*

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Name_____Date of Birth_____

Please list your reasons for this consultation _____
_____

Is this auto or work related? _____Y _____N If yes, date of accident_____

**PAST MEDICAL HISTORY**
Have you ever had or been treated for any of the following: (Please check all that apply)

_High blood pressure
_Swelling of ankles or feet
_Cataract/glaucoma
_Pneumonia
_Frequent or severe headaches
_Eye injury/disease
_Coughing/vomiting blood
_Back problems/pain
_Loss of appetite/nausea/vomiting
_Anxiety
_Excessive worry/depression
_Heart attack/MI
_Diabetes
_Shortness of breath
_Emphysema/COPD/lung trouble
_Weakness/numbness in a limb
_OTHER(explain below)

_Dizziness
_Stroke
_Rheumatic fever
_Double vision/blindness
_Recent gain/loss of weight
_Congestive heart failure
_Arthritis/joint pain
_Palpitations
_Broken bones/bone disease
_Peptic/stomach ulcer
_Bladder infection
_Difficulty in sleeping
_Changes in bowel habit/bleeding
_Thyroid problem
_Liver disease/jaundice/hepatitis
_Asthma/wheezing

_Severe ear, nose, throat trouble
_Neuritis
_Head injury
_Mitral valve prolapse
_Indigestion/GERD/reflux
_Excessive tiredness/fatigue
_Pacemaker/AICD
_Chills/fever/night sweats
_Chest pain/pressure
_Gout
_Skin rash/disease
_Kidney stone/blood in urine
_Anemia
_Bleeding disorder/blood/clot/DVT
_Aids/ARC
_Epilepsy/seizure disorder

Please explain the above if necessary and list any other medical history _____
_____
_____

Have you ever consulted or been treated by a **psychiatrist or psychologist**? ____Y ____N
If yes, please explain circumstances _____
_____

Women: Are you, or might you possibly be **pregnant**? ____YES ____ NO Taking oral contraceptives? _____Yes_____No
Number of Term Pregnancies_____ Number of Children Breastfed_____

**PAST SURGICAL HISTORY**
Please list all prior surgeries, including cosmetic surgeries. _____
_____

Were there any complications? ____ Y ____ N If yes, please list complications:
_____
_____

Have you or a family member had any problems with anesthesia? ____Y____N
If yes, please explain circumstances:_____
_____

**MEDICATIONS**
Do you take **blood thinners**, aspirin or non-steroidal anti-inflammatories (NSAIDs)? ____ YES ____ NO
If yes, please list:_____

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Are you allergic to latex? ____Y ____N

Are you allergic to any medications? ____Y ____N If yes, please list:

_____

_____

List all medications you are presently taking including strength and how often:

1._____ _____mg ____ times a Day
2._____ _____mg ____ times a Day
3._____ _____mg ____ times a Day
4._____ _____mg ____ times a Day
5._____ _____mg ____ times a Day

(For additional medication, please use the back of this form)

Please list ALL vitamins, supplements, and/or herbs you are presently taking: _____

_____

**SOCIAL HISTORY**

Marital Status Single___ Married___ Divorced___ Widow___
Are you employed Y_____ N_____ If yes, what is your occupation?_____
Do you live alone? Y_____ N_____

Are you currently under treatment **for alcohol or drug abuse**? ___YES ___ NO
How much alcohol do you consume in one week? ___ None ___ Light ___ Moderate ___ Heavy Quit date_____

Do you presently **smoke**? ___ YES ___ NO If yes, how many packs per day? _____ How long? _____
Have you ever smoked? ___ YES ___ NO Quit date_____

**FAMILY HISTORY**

(List any type of cancer or other major illness such as diabetes, heart disease, and etc.)

Mother Alive_____ List illnesses_____
Deceased_____ List cause of death_____

Father Alive_____ List illnesses_____
Deceased_____ List cause of death_____

Sister Alive_____ List illnesses_____
Deceased_____ List cause of death_____

Brother Alive_____ List illnesses_____
Deceased_____ List cause of death_____

*I attest that the above information is complete and accurate.*

_____ _____
Patient Signature/Guardian Signature (if under 18) Date