KITTO PLASTIC SURGERY
Inzhili Kitto M.D.

Plastic, Aesthetic & Reconstructive Surgery

Patient Demographics Form

Please complete all forms in its entirety. Be sure to initial at the bottom of each page prior to proceeding, in acknowledgement that all of your questions pertaining to the form have been answered.

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Email: _____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Address:_____ Apt #:_____

City:_____ State: _____ Zip:_____

Pharmacy:_____ Pharmacy Address:_____

Emergency Contact Name & Phone Number:_____

Primary Care Physician:_____

Referring Physician:_____

Other Care Providers:_____

Health History

Reason for Today's Visit:_____

Height:_____ Weight: _____ Gender: M | F

Do you have, or have you had any of the following conditions: (please check all that apply)

☐ Anemia	☐ Cataracts	☐ Hay Fever	☐ Liver Disease
☐ Anxiety	☐ Change of Moles	☐ Heart Disease	☐ Migraines
☐ Asthma	☐ Colitis	☐ Hepatitis	☐ Non-Healing Sore
☐ Arthritis	☐ CVA/Stroke	☐ Hernia	☐ Prostate Problem
☐ Back Pain	☐ Depression	☐ HSV 1 or 2 or both	☐ Psychiatric Issues
☐ Bladder Disorder	☐ Diabetes	☐ HIV/AIDS	☐ Scars
☐ Bleeding Disorder	☐ Drug Abuse	☐ High Blood Pressure	☐ Skin Cancer
☐ Breast Lump	☐ Fractures	☐ High Cholesterol	☐ Stomach Ulcers
☐ Breast Cancer	☐ Glaucoma	☐ Infectious Disease(s)	☐ Thyroid Disorder
☐ Bronchitis	☐ Gout	☐ Irregular Heartbeat	☐ Weight Loss
☐ Cancer: _____	☐ GERD	☐ Leukemia	☐ Other: _____

Please list any **Medical Conditions** you are currently being treated for or have had in the past, including significant trauma or injuries requiring hospitalizations not listed above:

_____

_____

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Please list any **surgeries** you have had, including the date of the operation(s):

_____
_____
_____

Date of last Tetanus Immunization: _____

Occupation: _____

Please circle YES or NO for the following questions:

Do you *smoke*? YES NO If yes, how much? _____

Do you *drink alcohol*? YES NO If yes, how much? _____

Do you *drink caffeine*? YES NO If yes, how much? _____

Do you have a *history of drug or alcohol abuse*? YES NO

Have you ever had a *blood transfusion*? YES NO

Please list the **Current Medications/Dosages** you are taking, including vitamins and herbal medications:

_____
_____
_____
_____

Please list any **Allergies**:

_____
_____
_____

Family history: List any medical conditions your blood relatives have or had:

Mother:_____ Father: _____

Sister: _____ Brother: _____

Grandmother: _____ Grandfather: _____

Other: _____

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Female Patients Only:

Pregnancy Number of pregnancies? _____ Number of deliveries? _____
Number of vaginal deliveries: _____ Number of C-Sections: _____

Are you currently pregnant? YES NO

Female **Breast** Patients Only:

Do you regularly have a Mammogram? YES NO If yes, date of last exam: _____

Current bra size: _____ Date of last menstrual cycle: _____

How did you hear about us?

___ Referral - *If yes*, who? _____

___ Social Media - *If yes*, circle the appropriate account. Instagram Facebook Google
Other: _____

___ Billboard - *If yes*, circle the location. Midlothian Turnpike Downtown Richmond

___ Insurance Company

___ Other - (Please specify) _____

Please check any services you are interested in:

☐ Facials ☐ Microneedling ☐ Botox ☐ Fillers ☐ Dermaplaning

☐ Peels ☐Other: _____

Are you interested in a complimentary skin consultation? YES NO

I certify that the above information is correct to the best of my knowledge. I will not hold my Physician or any member of her staff responsible for any errors of omission that I may have made in the completion of this form.

Patient Name: _____

Patient Signature:_____

Date: _____