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Pickens  
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**\*\*PLEASE PRINT INFO ON THIS FORM\*\***  
**PATIENT INFORMATION**  
**FOR SURGERY, WEIGHT LOSS AND SKIN CARE PATIENTS**

TODAY'S DATE: \_\_\_\_\_

PATIENT LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_  
MIDDLE INITIAL: \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ HOME ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
SOCIAL SECURITY #: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

CIRCLE MARITAL STATUS:    SINGLE    DIVORCED    MARRIED    OTHER:  
SPOUSE'S NAME: \_\_\_\_\_ SPOUSE'S EMPLOYER: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

DO YOU HAVE CHILDREN? \_\_\_\_\_ HOW MANY? \_\_\_\_\_ AGE OF YOUNGEST: \_\_\_\_\_  
ARE YOU PREGNANT OR PLANNING TO GET PREGNANT? \_\_\_\_\_

\*\*DO YOU SMOKE? \_\_\_\_\_ HOW MANY PACKS PER DAY? \_\_\_\_\_ \*\*  
DO YOU EXERCISE? \_\_\_\_\_ HOW OFTEN? \_\_\_\_\_  
WHAT TYPE OF EXERCISE? \_\_\_\_\_

WHEN WAS YOUR LAST PHYSICAL: \_\_\_\_\_  
PHYSICIAN'S FULL NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

PAST ILLNESSES: \_\_\_\_\_  
\_\_\_\_\_

PAST SURGERIES: \_\_\_\_\_  
\_\_\_\_\_

ALLERGIC TO ANY MEDICATIONS: YES \_\_\_\_\_ NO \_\_\_\_\_

IF ALLERGIC, WHAT MEDICATIONS: \_\_\_\_\_

WHAT REGULAR MEDICATIONS TO YOU TAKE? PLEASE LIST  
NAME OF MED.                      DOSAGE                      HOW OFTEN                      REASON  
\_\_\_\_\_  
\_\_\_\_\_

WHAT SUPPLEMENTS/VITAMINS DO YOU TAKE? PLEASE LIST  
NAME                      DOSAGE                      HOW OFTEN                      REASON  
\_\_\_\_\_  
\_\_\_\_\_

DO YOU HAVE ASTHMA OR RESPIRATORY PROBLEMS? EXPLAIN IF YES:  
\_\_\_\_\_

DO YOU TAKE MEDICATION TO CONTROL BLOOD PRESSURE?  
NAME, DOSAGE OB BP MEDS  
\_\_\_\_\_

OVER, PLEASE

REASON FOR VISIT: \_\_\_\_\_

DESCRIBE PREVIOUS METHODS UTILIZED TO LOSE WEIGHT: \_\_\_\_\_

HOW WERE YOU REFERRED TO THIS OFFICE: \_\_\_\_\_

**FEES ARE PAYABLE AT THE TIME OF SERVICE.**

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What procedures are you interested in?

- |   |  |
|---|--|
| <input type="checkbox"/> Weight Loss Program                    | <input type="checkbox"/> Facial Resurfacing                  |
| <input type="checkbox"/> Hormone Replacement                    | <input type="checkbox"/> (Wellness Consultation/Supplements) |
| <input type="checkbox"/> Skin Care                              | <input type="checkbox"/> Breast Augmentation                 |
| <input type="checkbox"/> Microdermabrasion                      | <input type="checkbox"/> Breast Reduction                    |
| <input type="checkbox"/> Microdermabrasion with Chemical Peel   | <input type="checkbox"/> Rhinoplasty                         |
| <input type="checkbox"/> Non-Surgical Thinning Hair Treatment   | <input type="checkbox"/> Liposuction/lipo-dissolve           |
| <input type="checkbox"/> Non-Surgical Body Contouring(Synergie) | <input type="checkbox"/> Botox                               |
| <input type="checkbox"/> Juvederm, Sculptra Fillers             | <input type="checkbox"/> Tummy Tuck                          |

Past Medical History:

(Please circle any illnesses that you have been treated for: items not circled are understood to be negative)

Abnormal Bleeding	Pneumonia	Cancer	Diabetes	Heart Disease
High Blood Pressure	Ulcer	Hepatitis	Kidney Disease	Anemia
AIDS/HIV Positive	Arthritis	Liver Disease	Asthma	Gout
Peripheral Vascular Disease	Anxiety	Emphysema	Phlebitis	Stroke
Rheumatic Fever	Tuberculosis	Blood Clot	Epilepsy/Seizure	
Previous Back/Neck Injury	Polio	Osteoporosis	Thyroid Disorder	

Other: \_\_\_\_\_ NONE

(Please circle any conditions your family members have: items not circled are understood to be negative)

Abnormal Bleeding	Rheumatoid Arthritis	Bleeding Ulcer	Osteoporosis	Cancer
Ankylosing Spondylitis	Bone Disease	Lupus	Gout	Hypertension
Heart Disease	Ulcerative Colitis	Crohns Disease	Stroke	Diabetes

Is there any other information you would like us to be aware of :

I verify that the above is an accurate representation of my past and current health.

SIGNATURE OF PATIENT \_\_\_\_\_

DATE: \_\_\_\_\_