Welcome

ABOUT YOU

Today's Date: _____ Email: _____ Patient ID #: _____

Name: _____ I prefer to be called: _____ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: _____
Street City State Zip

Home Phone #: (____)_____ Cell #: (____)_____ Do you accept texts? ____ Work Phone #: (____)_____ Ext: _____

Driver's Lic #: _____ Where & when are best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Emergency Contact

His / Her Name: _____ Relation: _____ Work Phone #: (____)_____ Home Phone #: (____)_____

Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Work Phone #: (____)_____ Social Security #: _____

Employer: _____ Work Phone #: (____)_____ Ext: ____ Driver's License #: _____

Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (____)_____ Ext: ____ Driver's License #: _____

CONTINUED ON BACK

HEALTH HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Address: _____
Street

_____
City State Zip

Phone #: (___)_____ Date of last visit: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Are you being treated for any medical condition at this time? ❑ Yes ❑ No

If yes please explain: _____

Date of last physical exam: _____

Have you been treated for psychological problems like nervous depression? ❑ Yes ❑ No

If yes please explain: _____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Do you drink alcoholic beverages? ❑ Yes ❑ No

Do you wear contacts? ❑ Yes ❑ No

Do you wear dentures? ❑ Yes ❑ No

Do you bleed easily from cuts or surgery? ❑ Yes ❑ No

Do you form large scars or keloids? ❑ Yes ❑ No

Do you have frequent boils or infections? ❑ Yes ❑ No

Have you ever had any previous cosmetic surgery performed? ❑ Yes ❑ No

Purpose of visit/procedure: _____

Have you seen other plastic surgeons for the same problem that brings you here today? _____

Name of Plastic Surgeon: _____

Is this the result of a personal injury? ❑ Yes ❑ No If yes, date _____

Is this the result of a work related injury? ❑ Yes ❑ No If yes, date _____

Besides the reason for this consultation, would you like the Dr. to cover other procedures that would enhance your appearance? ❑ Yes ❑ No

Do you have any personal problem that preoccupies you, that you would like to share with the Dr.? ❑ Yes ❑ No

List all operations in the past: _____

For Women: You cannot have surgery if you are pregnant.

Are you pregnant? Week # _____ ❑ Unsure ❑ Yes ❑ No

Date of last mammogram? _____

Birth control method used? _____

Number of pregnancies: _____ Number of children you delivered: _____

Problem or complications during pregnancy, labor or delivery: _____

Have you had any cancers? Breast, cervical, ovarian, other _____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Iodine	Y N	Sedatives
Y N	Barbiturates	Y N	Jewelry	Y N	Sulfa Drugs
Y N	Codeine or other Narcotics	Y N	Latex	Y N	Tetracycline
Y N	Erythromycin	Y N	Penicillin	Y N	Other

Do you have any allergies to anesthesia? ❑ Yes ❑ No

If yes please explain: _____

Do you have an allergy to tape? ❑ Yes ❑ No

Please list additional drugs/items that cause allergic reactions: _____

Medications: List all medications you are presently taking (Including non-prescription):

	Name	Dosage	How Often Taken
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Consumption of the following:

Aspirin	❑ Yes ❑ No	Daily Amount ____	Weekly Amount ____	
Ibuprofen (Advil, Motrin, Nuprin)	❑ Yes ❑ No	Daily Amount ____	Weekly Amount ____	
Tylenol	❑ Yes ❑ No	Daily Amount ____	Weekly Amount ____	
Alcohol	❑ Yes ❑ No	Daily Amount ____	Weekly Amount ____	
Tobacco	❑ Yes ❑ No	Daily Amount ____	Weekly Amount ____	
Other _____	❑ Yes ❑ No	Daily Amount ____	Weekly Amount ____	
Other _____	❑ Yes ❑ No	Daily Amount ____	Weekly Amount ____	

Do you presently have or have you experienced the following?

Y N	Abnormal Bleeding	Y N	Chicken Pox	Y N	Glaucoma	Y N	Low Blood Pressure	Y N	Seizures
Y N	Acquired Immune Deficiency Syndrome	Y N	Colitis	Y N	Hay Fever	Y N	Lupus	Y N	Shingles
		Y N	Congenital Heart Defect	Y N	Heart Trouble	Y N	Mental Illness	Y N	Sickle Cell Disease
Y N	Alcohol Abuse	Y N	Diabetes	Y N	Hemophilia	Y N	Mitral Valve Prolapse	Y N	Sinus Problems
Y N	Anemia	Y N	Difficulty Breathing	Y N	Hepatitis	Y N	Pacemaker	Y N	Stroke
Y N	Arthritis	Y N	Drug Abuse	Y N	Herpes	Y N	Persistent Cough	Y N	Thyroid Problems
Y N	Artificial Bones/Joints	Y N	Emphysema	Y N	High Blood Pressure	Y N	Psychiatric Problems	Y N	Tonsillitis
Y N	Artificial Valves	Y N	Epilepsy	Y N	HIV+	Y N	Radiation Treatment	Y N	Tuberculosis (TB)
Y N	Asthma	Y N	Fainting Spells	Y N	Hospitalized for Any Reason	Y N	Reproductive disorders	Y N	Ulcers
Y N	Cancer	Y N	Fever Blisters	Y N	Kidney Problems	Y N	Rheumatic Fever	Y N	Venereal Disease (VD)
Y N	Chemotherapy	Y N	Frequent Headaches	Y N	Liver Problems	Y N	Scarlet Fever		

Please list any other serious medical condition(s) that you have experienced: _____

PLEASE NOTE: It is mandatory for patients who do smoke to Quit smoking TWO WEEKS before surgery and a minimum of TWO WEEKS after the procedure. IF YOU THINK THAT YOU CANNOT REFRAIN FROM SMOKING THIS LONG, PLEASE TELL US...!!!

Yes, I can refrain from smoking _____ No, I cannot _____ Patient's Signature: _____ Date: _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____
Signature Date