WELCOME

PLEASE PRINT

Today's Date:_____ **Email address:**_____

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/P O Box City State Zip

Home Phone # (_____)_____-_____**Cell/Pager# (**_____) _____-_____**Work Phone # (**_____)_____ _____**Ext.**_____**Driver's License #**_____

Where & when are the best times to reach you?_____ **Whom may we thank for referring you?**_____

Other family member(s)seen by us:_____

Employer:_____**How long there?**_____**Occupation**_____

Employer's address:_____
Street/P O Box City State Zip

Neighbor or relative not living with you

His/Her Name_____**Relation**_____**Work Phone #(**_____)_____-_____ **Home Phone# (**_____)_____ _____

Address:_____
Street City State Zip

Person responsible for account if other than yourself

Name_____**Relation:**_____**Home Phone # (**_____) _____ _____**Social Security#**_____-_____-_____

Employer_____**Work Phone #(**_____) _____ _____**Ext.**_____ **Driver's License**_____

Billing Address:_____
Street/P O Box City State Zip

SPOUSE INFORMATION

His/Her Name_____**Birthdate**_____/_____/_____ **Social Security #** _____ - _____- _____

Employer:_____

FAMILY HISTORY

Family Health History

Relationship	Age, if Living	Age at Death & Cause of Death
Mother	_____	_____
Father	_____	_____

Siblings (specify which gender)	Age, if living	Age of death
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Medical Problems

Please identify any medical problems blood relatives have or ever had:

Condition			Family Member (s)
Birth Defects	□ Yes	□ No	_____
Genetic Defects	□ Yes	□ No	_____
Mental Retardation	□ Yes	□ No	_____
Allergies	□ Yes	□ No	_____
Lung Disease	□ Yes	□ No	_____
Asthma	□ Yes	□ No	_____

Condition			Family Members (s)
Bone/Joint Disorders	□ Yes	□ No	_____
Rheumatoid Arthritis	□ Yes	□ No	_____
Muscle Disorders	□ Yes	□ No	_____
Skin Diseases	□ Yes	□ No	_____
Eye or Ear disorders	□ Yes	□ No	_____
Cancer	□ Yes	□ No	_____
Diabetes	□ Yes	□ No	_____
Thyroid Disease	□ Yes	□ No	_____
Heart Disease/Problems	□ Yes	□ No	_____
Anemia Blood Disorders	□ Yes	□ No	_____
High Blood Pressure	□ Yes	□ No	_____
Kidney Disease/Problems	□ Yes	□ No	_____
Rheumatic Fever	□ Yes	□ No	_____
Tuberculosis (TB)	□ Yes	□ No	_____
Seizures/Convulsions	□ Yes	□ No	_____
Mental Disease/Disorder	□ Yes	□ No	_____
Venereal Disease (VD)	□ Yes	□ No	_____
HIV/AIDS	□ Yes	□ No	_____
Other _____	□ Yes	□ No	_____

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 your last physical exam:_____
Have you been treated for psychological problems like anxiety or depression? □ Yes □ No

_____
If yes, please explain:_____

Your nationality?_____
Do you smoke or use tobacco in any 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 excessively 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 procedure that brings you here today?

□ Yes □ No **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? □ Unsure □ Yes □ No **Week #**_____ _____

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 concerns? Breast, cervical, ovarian, other:_____
_____

Are you allergic to any of the following?

□ Yes □ No	Aspirin	□ Yes □ No	Latex
□ Yes □ No	Sedatives	□ Yes □ No	Penicillin
□ Yes □ No	Barbiturates	□ Yes □ No	Sulfa Drugs
□ Yes □ No	Codeine or other Narcotics	□ Yes □ No	Tetracycline
□ Yes □ No	Erythromycin	□ Yes □ No	Other
□ Yes □ No	Iodine		

Do you have any allergies to anesthesia?

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**_____	**Alcohol**	□ Yes □ No	**Daily Amount**_____	**Weekly Amount**_____
Ibuprofen (Advil, Motrin, Nuprin)	□ Yes □ No	**Daily Amount**_____	**Weekly Amount**_____	**Tobacco**	□ Yes □ No	**Daily Amount**_____	**Weekly Amount**_____
Tylenol	□ 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	Smoke
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 Positive	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
Y N	Chemotherapy	Y N	Frequent Headaches	Y N	Liver Problems	Y N	Scarlet Fever		

Please list any 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.

Patient's Signature_____**Date:**_____