

Today's Date: \_\_\_\_\_ (Please Print Legibly)

Patient's Name

\_\_\_\_\_ First Middle Last

Address

\_\_\_\_\_ Street & Apt # City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Any restrictions for contacting you?  No  Yes E-mail \_\_\_\_\_

Contact Restrictions: \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ Gender  Female  Male

Marital Status  Single  Married to: \_\_\_\_\_  Other: \_\_\_\_\_

Patient's Employer

\_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext: \_\_\_\_\_ Is it okay to call you at work?  Yes  No

Address

\_\_\_\_\_ Street & Suite # City State Zip

How did you hear about us ?

- Best Self  Creative Loafing  Locateadoc.com  Yellow Pages  Implant Info.com
- Plastic Surgery.com  Breast Implants USA.com  Web-site  Implant Forum.com
- Friend/Relative: \_\_\_\_\_  Doctor: \_\_\_\_\_  Other: \_\_\_\_\_

If you were referred by a specific person, may we thank them?  Yes  No

Emergency Contact

(Not in your household)

\_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Areas of Interest: (mark all that apply)

Facial Procedures

- Blepharoplasty (Eyelid Lift)
- Botox
- Brow or Forehead Lift
- Earlobe Repair
- Facial Liposuction (Neck, Jowls)
- Face or Neck Lift
- Lip Enhancement
- Otoplasty (Ear Pinning)
- Rhinoplasty (Nose Reshaping)
- Skin Resurfacing ( Peel, Etc.)
- Chin
- Wrinkle Fillers (Injections)

Breast Procedures

- Breast Augmentation
- Breast Reduction
- Mastopexy (Breast Lift)
- Nipple Reduction or Inversion

Body Procedures

- Abdominoplasty (Tummy Tuck)
- Brachioplasty (Arm Lift)
- Labia
- Liposuction (Thighs, Abdomen, Etc.)
- Thigh Lift

Other Procedures

- Skin Care
- Telangectasia (spider veins)
- Laser Hair Removal
- Lesions / Moles
- Other \_\_\_\_\_

Height: \_\_\_\_\_ ft \_\_\_\_\_ in Weight: \_\_\_\_\_ lbs.

**DO YOU NOW OR HAVE YOU EVER HAD** ..... ( You must circle an answer for each individual item)

Heart Trouble	Yes	No
Heart Attack	Yes	No
Heart Pain	Yes	No
Palpitation or Irregular Pulse	Yes	No
Extra Heart Beats	Yes	No
Stroke	Yes	No
Hypertension	Yes	No
Blood Pressure Abnormalities	Yes	No
Abnormal EKG	Yes	No
Rheumatic Fever	Yes	No
Dropsy or Heart Failure	Yes	No
Digitalis Treatment	Yes	No
Shortness of Breath	Yes	No
Chest Pain	Yes	No
Asthma	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Tuberculosis	Yes	No
Smokers Cough	Yes	No
Emphysema	Yes	No
Coughing or Spitting of Blood	Yes	No
Hay Fever	Yes	No
Major Allergies	Yes	No
Palsy or Paralysis	Yes	No
Nervous Breakdown	Yes	No
Nervous Disorder	Yes	No
Insomnia	Yes	No
Drug Habit	Yes	No
Self-Destructive Tendencies	Yes	No
Psychiatric Hospitalization or Care	Yes	No
Thyroid Problems	Yes	No
Kidney or Renal Disease	Yes	No
Heart murmur	Yes	No
Piercing other than the ears	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No
Missed or irregular last menstrual period	Yes	No
Family history of cancer, heart trouble, stroke	Yes	No

Glaucoma or Eye Problems	Yes	No
Visual Disturbances	Yes	No
Error in Refraction	Yes	No
Other Eye Problems	Yes	No
Hepatitis	Yes	No
Yellow Jaundice	Yes	No
Gallstones or Gallbladder Trouble	Yes	No
Cirrhosis of the Liver	Yes	No
Alcoholism or Drug Dependency	Yes	No
Esophageal Varices	Yes	No
Frequent Indigestion	Yes	No
Ulcers	Yes	No
Gastritis	Yes	No
Colitis	Yes	No
Problem Constipation	Yes	No
Vomiting Blood	Yes	No
Tarry or Bloody Bowel Movements	Yes	No
Hemorrhoids	Yes	No
Goiter or Thyroid Disorders	Yes	No
Diabetes	Yes	No
Skin Disorders	Yes	No
Arthritis	Yes	No
Fracture of Neck or Spine	Yes	No
Bleeding Tendency or Disorder	Yes	No
Abnormal Bleeding after Tooth Extraction	Yes	No
Airway Obstruction (Nasal)	Yes	No
Breast Cysts, Tumors, Abscesses	Yes	No
Nipple Discharge (Apart from Normal Lactation)	Yes	No
Kidney Disorder	Yes	No
Blood Transfusion	Yes	No
Seizures or convulsions or fainting spells	Yes	No
Black outs	Yes	No
Dentures, bridges, capped teeth or crowns	Yes	No
Loose teeth	Yes	No
Cosmetic bonding to teeth	Yes	No
Any family members with bleeding problems	Yes	No
Any family members with anesthesia problems	Yes	No

Please list all present medications , including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. Include over-the-counter medications.

1. Do you have an allergic reaction to any medication?  Yes  No Which? \_\_\_\_\_
2. Do you react abnormally to any medication?  Yes  No Which? \_\_\_\_\_
3. Are you allergic to Latex?  Yes  No
4. Are you allergic to Iodine  Yes  No

5. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?  
 Yes  No If yes, when and where? \_\_\_\_\_  
 Age, if living: \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Siblings.  
 If applicable list age at death and cause of death: \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Siblings
6. Have you ever been on cortisone or steroid treatment?  Yes  No When? \_\_\_\_\_
7. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?  
 Yes  No If so, how much? \_\_\_\_\_
8. Do you smoke?  Yes  No If so, how much? \_\_\_\_\_ For how long? \_\_\_\_\_
9. Are you pregnant?  Yes  No When was you last normal menstrual period? \_\_\_\_\_  
**(You can not have surgery if you are pregnant)**
10. How many pregnancies? \_\_\_\_\_ Births? \_\_\_\_\_ Breast Fed?  Yes  No How long? \_\_\_\_\_  
 CHILDREN (list names and ages/birthdays): \_\_\_\_\_  
 \_\_\_\_\_
11. What form of Birth Control method do you use? \_\_\_\_\_
12. When was your last physical exam? \_\_\_\_\_ By whom? \_\_\_\_\_
13. Your current physical health is  Good  Fair  Poor
14. When was your last eye examination? \_\_\_\_\_ By whom? \_\_\_\_\_  
 When and where was your last CHEST X-RAY? \_\_\_\_\_  
 MAMMOGRAM? \_\_\_\_\_ EKG? \_\_\_\_\_
15. Who is your personal physician, if any? \_\_\_\_\_ Please list all physicians presently caring for you with phone number. \_\_\_\_\_
16. Have you ever been under psychiatric care?  Yes  No When? \_\_\_\_\_ Why? \_\_\_\_\_
17. Have you had any recent blood work done?  Yes  No Where? \_\_\_\_\_
18. Do you have sleep apnea?  Yes  No
19. Is there anything else you think the doctor should know? \_\_\_\_\_  
 \_\_\_\_\_
20. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:  
 SURGICAL OPERATIONS (include where, when and why for each surgery): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 HOSPITALIZATIONS (include where, when and why for each admission): \_\_\_\_\_  
 \_\_\_\_\_

I agree to stop smoking 2 weeks before and 2 weeks after Surgery.  Yes  No

**By signing below, I agree that the above information is complete and accurate to the best of my knowledge.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_