

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: _____