

PLASTIC SURGERY PATIENT INFORMATION

Date _____

Salutation _____ First Name _____ Middle Initial _____ Last Name _____ Home # () _____

Address _____ Work # () _____

City _____ State _____ Zip _____ Cell # () _____

E-Mail _____ Other # () _____

Marital Status _____ Name of Spouse _____ Fax # () _____

Birth Date _____ Age _____ Sex _____ SS# _____

Occupation _____

Company _____

Address _____

City _____ State _____ Zip _____

Emergency Contact

Name _____

Address _____

City _____ St _____ Zip _____

Telephone # _____

Relationship to you _____

How did you hear about us: (Please check all that apply)

INTERNET

Patient Referral Patient's Name _____

Physician Referral

Physician's Name _____

Address: _____

City _____

State _____ Zip Code _____

Primary Care Physician:

Name: _____

Address: _____

City: _____

State: _____ Zip code _____

Google.com Obesity.com Enhance.com
Other _____

Phone # () _____

Fax # () _____

Phone # () _____

Fax # () _____

Primary reason for visit:

Other procedures that I am interested in (Please check all that apply)

Liposuction Face Lift Breast Augmentation Scar Revisions

Tummy Tuck Neck Lift Breast Reduction Botox Injections

Body Lift Eyelid Surgery Breast Lift Restylane Injections

Arm Lift Brow Lift Male Breast Surgery Radiesse Injections

Buttock Lift Forehead Lift Chemical Peels

Thigh Lift Nose Surgery Fat Grafting

Past Surgical History

Please list all operations you have had below including plastic and cosmetic Procedures

Date	___/___/___	Type	_____
Date	___/___/___	Type	_____
Date	___/___/___	Type	_____
Date	___/___/___	Type	_____
Date	___/___/___	Type	_____
Date	___/___/___	Type	_____
Date	___/___/___	Type	_____
Date	___/___/___	Type	_____

Past Medical History

	Currently	In the Past
Chicken Pox	_____	_____
Measels	_____	_____
Mumps	_____	_____
German Measels	_____	_____
Kidney Disease	_____	_____
Hypertension	_____	_____
Arthritis	_____	_____
Asthma	_____	_____
Emphysema	_____	_____
Respiratory Problems	_____	_____
Seizures	_____	_____
Cancer	_____	_____
Rheumatic Fever	_____	_____
Scarlet Fever	_____	_____
Polio	_____	_____
Tuberculosis	_____	_____
Hepatitis	_____	_____
Diabetes	_____	_____
Heart Disease	_____	_____
Heart Attack	_____	_____
Angina	_____	_____
Stroke	_____	_____
Anemia	_____	_____
Bleeding Tendency	Yes	No
Zoster	Yes	No
Herpes	Yes	No
HIV or AIDS	Yes	No
DVT (blood clot in legs)	Yes	No
Pulmonary Embolism	Yes	No

Breast History

Date of last mammogram ___/___/___

History of breast cancer? Yes No

Family member Yes No

If yes:

Mother ___ Sister ___ Aunt ___ Grandmother ___

Skin Cancer History

Melanoma	Yes	No
Basal Cell	Yes	No
Squamous Cell	Yes	No

Habits & Psychiatric History

Do you drink alcohol? Yes No How much? _____

Do you smoke? Yes No How much? _____

If no, did you ever? Yes No

When did you quit? _____

Do you use any recreational drugs? Yes No

Marijuana ___ Cocaine ___ Heroin ___ Other _____

Have you suffered from any mental illness? Yes No

Have you ever been hospitalized for a mental illness? Yes No

Menstrual History

Number of pregnancies _____ Number of children _____

Birth control pills _____ Other contraceptive therapy _____

Family History

Have any of your close relatives had any of these diseases? (Mother, Father, Sister, Brother, Daughter, Son)

Diabetes	_____	
Heart Disease	_____	
Heart Attack	_____	
Hypertension	_____	
Stroke	_____	
Cancer	_____	
Bleeding Tendency	_____	If yes, what type? _____
Anemia	_____	
Mental Disorder	_____	

Maximum Weight

Date ___/___/___ Weight _____ BMI _____

Current Weight _____ Height - Feet _____ Inches _____

Medications

Please list all medications you take including prescription medications, birth control and over-the-counter medications (i.e. Tylenol, aspirin, Advil, Motrin, etc.)

Medication _____	Dosage _____	How Often? _____
Medication _____	Dosage _____	How Often? _____
Medication _____	Dosage _____	How Often? _____
Medication _____	Dosage _____	How Often? _____
Medication _____	Dosage _____	How Often? _____
Medication _____	Dosage _____	How Often? _____
Medication _____	Dosage _____	How Often? _____
Medication _____	Dosage _____	How Often? _____
Medication _____	Dosage _____	How Often? _____
Medication _____	Dosage _____	How Often? _____
Medication _____	Dosage _____	How Often? _____

Allergies

Please list all medications and foods that you are allergic to:

Medication _____	Reaction _____
Medication _____	Reaction _____
Medication _____	Reaction _____
Medication _____	Reaction _____
Medication _____	Reaction _____

Do you have a latex allergy? Yes _____ No _____

Can you receive blood products? Yes _____ No _____

I attest, by my signature below, that the medical information I have given above is accurate and true.

Signature of patient or authorized party _____ Date _____