

Name _____ Date of Birth _____ Today's Date _____

Occupation _____ Marital Status: S, M, D, Sep

How were you referred to us? _____

Which procedures are you interested in? (please circle)

Face or Neck Lift Eyelids Rhinoplasty (nose) Chin or Cheek Implants Laser resurfacing Injectable Filler

Glycolic Peel/Chemical Peel Microdermabrasion Scar Revision Botox/Dysport Liposuction

Lipodystrophy treatment Removal of Cysts, Warts, Moles, etc. Protruding ear correction Fat reduction/Zeltiq Coolsculpting

Propecia Skin Cancer Removal/Reconstruction Wrinkle/Fold improvement Forehead/Brow Lift

Other _____

What specifically do you wish to have corrected: (what don't you like about the above conditions?)

When did you begin to consider surgical or medical correction? _____

Is having surgery your idea or is it someone else's idea? _____

Why have you decided to have it done at this time? _____

Have you consulted any other doctor about this? (when?) _____

Have you discussed this surgery with your family? Yes / No Are they agreeable? Yes / No

Do you understand that the object of any cosmetic operation is improvement in appearance, not perfection? Yes / No

Are you aware that the results of the operation might not fully meet your expectations? Yes / No

Have you had any previous cosmetic surgery? Yes / No When, and what was done? _____

Who performed the surgery? _____ Where was it performed? _____

Were you satisfied with the results? _____ If not, why? _____

Have you had any other surgery, or an injury, to the face, nose, neck or eyes? Yes / No When? _____

Describe _____

Has anyone in your family or a close friend had cosmetic or reconstructive surgery? Yes / No

What was done? _____ By whom? _____

Have you had any other prior surgery on any of the following areas? (What was done?): Teeth/gums _____

Skin _____ Head & neck _____ Chest _____

Abdomen _____ Reproductive system _____ Back, arms or legs _____

Were there any complications? _____ Did you have a normal recovery? _____

Were you satisfied with the results? _____ If not, why? _____

Have you ever been dissatisfied with the treatment you received from a doctor or dentist? Yes / No

Please list hobbies/sporting activities in which you participate _____

No / Yes Are you taking any drugs or medications?

Please list and indicate how often _____

No / Yes Have you ever received Accutane Treatment for your skin?

No / Yes Do you take aspirin-containing medications?

Please list _____

No / Yes Have you ever received local anesthesia (Novocaine or Xylocaine) by a dentist or doctor?

No / Yes Did you have any reaction to the anesthesia?

No / Yes Are you considered a healthy person?

No / Yes Do you take vitamins regularly?

No / Yes Do you have recurring fever blisters or herpes on the mouth or face?

No / Yes Have you ever been tested for HIV? If yes, when and what was the result? _____

Do you or any family members have:
(Circle if yes and indicate who)

- Heart Trouble _____
- High Blood Pressure _____
- Diabetes _____
- Arthritis _____
- Thyroid problems _____
- Tuberculosis _____
- Emotional problems _____
- Excessive bruisability _____
- Excessive scarring _____

Do you have a history of bleeding: (circle if yes)
From the nose In the Urine Vomiting blood
From the rectum Coughing up blood
Other _____

No / Yes Do your cuts bleed longer than other people's?

No / Yes Have you ever had a bleeding episode that required the attention of a doctor?

No / Yes Have you ever had excessive bleeding on more than one occasion?

No / Yes Have you have hay fever or asthma? (circle which one)

No / Yes Do you have frequent pains in the chest?

No / Yes Do you have stomach trouble or ulcers?

No / Yes Have you ever had liver or gall bladder trouble or "yellow jaundice"? (circle which one)

No / Yes Do you have frequent skin infections, irritations or rashes? (circle which one)

No / Yes Do you often have severe headaches or dizzy spells? (circle which one)

No / Yes Has any part of your body ever been paralyzed?

No / Yes Have you ever had a convulsion or seizure?

No / Yes Have you ever taken hormones or thyroid medication (circle which one)

No / Yes Have you ever been treated for anemia?

No / Yes Have you ever had loss of vision?

No / Yes Do you ever have blurred vision?

No / Yes Are you being treated for glaucoma?

No / Yes Are you frequently sick or ill?

No / Yes Do you worry about your health?

No / Yes Have you ever been treated for any sexually transmitted disease?

No / Yes Do you smoke? If yes, # of cigs/day: _____

No / Yes Have you smoked in the past? If yes, when did you quit? _____

No / Yes Do you drink more than 6 cups of coffee per day?

No / Yes Do you usually have 2 or more alcoholic drinks per day?

No / Yes Have you ever had a "nervous breakdown?"

No / Yes Do you usually feel unhappy?

No / Yes Have you ever received medical treatment for psychiatric or "nervous" condition?

No / Yes Do you often get depressed?

No / Yes Are you easily upset or irritated?

No / Yes Do strange places make you feel afraid?

No / Yes Are you considered a nervous person?

WOMEN ONLY:

No / Yes Are you pregnant?

When was your last menstrual period? _____

No / Yes Are your periods often irregular?

No / Yes Have you had gynecological problems?

Describe _____

MEN ONLY:

No / Yes Have you ever had prostate problems?

MEN/WOMEN

No / Yes Do you have any medical problems that have not been covered ?

Explain _____

No / Yes Are there any reasons you should not have surgery at the present time?

No / Yes Do you give consent and authorize the recommended diagnostic, medical, surgical, anesthetic and other diagnostic services that the doctor and his staff deem beneficial while you are under their care?

Signed _____ Date _____

The information you have provided is essential to our comprehensive evaluation of your case.
Please write down any questions you may have so we may discuss them in detail during your consultation period.