MICHAEL ECHAVEZ M.D.

Facial Plastic & Reconstructive Surgery
500 Sutter Street, Suite 430, San Francisco, CA 94102
415-392-9800 • sfplasticsurgery.com

Consultation & Medical Questionnaire

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 check)

❑ 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 - SculpSure or CoolSculpting.

❑ Propecia ❑ Skin Cancer Removal/Reconstruction ❑ Wrinkle/Fold improvement ❑ Forhead/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?_____

_____

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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 _____

_____

❑ Yes ❑ No Are you taking any drugs or medications?
Please list and indicate how often_____

_____

_____

_____

_____

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

❑ Yes ❑ No Do you take aspirin-containing medications?
Please list _____

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

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

❑ Yes ❑ No Are you considered a healthy person?

❑ Yes ❑ No Do you take vitamins regularly?

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

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

_____

Do you or any family members have:
(Check 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: (check if yes)
❑ From the nose ❑ In the Urine ❑ Vomiting blood
❑ From the rectum ❑ Coughing up blood
Other_____

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

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

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

❑ Yes ❑ No Have you have ❑ hay fever or ❑ asthma? (check which one)

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

❑ Yes ❑ No Do you have stomach trouble or ulcers?

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

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

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

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

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

❑ Yes ❑ No Have you ever taken ❑ hormones or ❑ thyroid medication? (check which one)

❑ Yes ❑ No Have you ever been treated for anemia?

❑ Yes ❑ No Have you ever had loss of vision?

❑ Yes ❑ No Do you ever have blurred vision?

❑ Yes ❑ No Are you being treated for glaucoma?

❑ Yes ❑ No Are you frequently sick or ill?

❑ Yes ❑ No Do you worry about your health?

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

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

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

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

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

❑ Yes ❑ No Do you usually feel unhappy?

❑ Yes ❑ No Do you often get depressed?

❑ Yes ❑ No Do strange places make you feel afraid?

❑ Yes ❑ No Are you considered a nervous person?

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

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

❑ Yes ❑ No Are you easily upset or irritated?

WOMEN ONLY:

❑ Yes ❑ No Are you pregnant? When was your last menstrual period? _____

❑ Yes ❑ No Are your periods often irregular? ❑ Yes ❑ No Have you had gynecological problems?

Describe _____

MEN ONLY:

❑ Yes ❑ No Have you ever had prostate problems?

MEN/WOMEN

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

Explain _____

_____

_____

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

❑ Yes ❑ No 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.