

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ May we thank them for referring you? \_\_\_\_\_

In which surgical procedures are you interested?

- Liposuction \_\_\_\_\_ Nasal Surgery \_\_\_\_\_ Eyelid Surgery \_\_\_\_\_ Face or Neck Lift \_\_\_\_\_ Forehead Lift \_\_\_\_\_  
 Laser Treatment \_\_\_\_\_ Protruding Ears \_\_\_\_\_ Lip Augmentation \_\_\_\_\_  
 Breast Enlargement \_\_\_\_\_ Breast Lift \_\_\_\_\_ Breast Reduction \_\_\_\_\_ Abdominoplasty (Tummy Tuck) \_\_\_\_\_  
 Hair Removal \_\_\_\_\_ Botox \_\_\_\_\_ Soft Tissue Filler for Lips/Lines \_\_\_\_\_  
 Other \_\_\_\_\_

Circle any of the following that you have experienced:

- |                     |                   |                    |                       |
|---------------------|-------------------|--------------------|-----------------------|
| Asthma              | Arthritis         | Venereal Disease   | Other Blood Problems  |
| Hay Fever           | Arthritis Therapy | HIV/AIDS           | Alcohol Abuse Therapy |
| Nasal Allergies     | Steroid Therapy   | Frequent Headaches | Bouts of Depression   |
| Visual Problems     | Poor Circulation  | Excess Scarring    | Bouts of Unhappiness  |
| Thyroid Therapy     | Kidney Trouble    | Dizziness          | Nervous Breakdown     |
| Frequent Chest Pain | Bladder Trouble   | Convulsions        | Psychiatric Therapy   |
| Lung Trouble        | Skin Infection    | Paralysis          | Stomach Ulcers        |
| Heart Trouble       | Skin Irritation   | Hormone Therapy    | Other Stomach Trouble |
| High Blood Pressure | Rashes            | Anemia             | Liver Trouble         |
| Diabetes            | Fever Blisters    | Profuse Bleeding   | Gall Bladder Trouble  |
| Yellow Jaundice     | Genital Herpes    | Excess Bruising    | Drug Abuse Therapy    |

No Yes Have you ever had any surgery or serious injury?  
 List them \_\_\_\_\_  
 \_\_\_\_\_

No Yes Are you now taking any medications?  
 List them \_\_\_\_\_  
 \_\_\_\_\_

No Yes Are you allergic to any medication? Do you have a latex allergy?  
 List them \_\_\_\_\_  
 \_\_\_\_\_

No Yes Do you take aspirin often?

No Yes Do you take herbal or homeopathic medicines?  
 List them \_\_\_\_\_  
 \_\_\_\_\_

No Yes Have you ever taken the drug "Acutane"? When? \_\_\_\_\_

No Yes Do you smoke? How much? \_\_\_\_\_

No Yes Do you drink alcohol? How much? \_\_\_\_\_

No Yes Have you had any previous anesthesia problems?  
 Explain \_\_\_\_\_  
 \_\_\_\_\_

When was your last physical examination? \_\_\_\_\_

Who is your family doctor? \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

No Yes Do you have any other medical problems that have not been covered?  
 Explain \_\_\_\_\_  
 \_\_\_\_\_