The following information will help us serve you better. Please make every effort to fill out the information fully and accurately. Please be sure to complete both sides of this form. Your responses are held strictly confidential.

PERSONAL INFORMATION

Name _____ Date of Birth ___ / ___ / ___ Age ___ Sex _____
S.S # _____ Height _____ Weight _____ Number of children _____
Home Address _____
City _____ State _____ Zip _____
Where May We Leave Messages? ( ) Home _____ ( ) Cell _____
( ) Work _____ ( ) Email _____ ( ) Spouse _____
( ) Other _____
Where Employed _____
Marital Status ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed
Name of Spouse _____ Spouse's Employer _____
In Case of Emergency, Contact _____
Relationship _____ Phone _____
Who is responsible for charges? _____

Please Circle Your Surgeries of Interest to Discuss:

Arms Breast Enlargement Breast Lift Breast Reduction Cheeks Chin Ears Eyelid

Face Liposuction Nose Neck Mouth Wrinkles Tummy Tuck Orthognathic Other

_____

Please use the space below to give us any other information you feel would be helpful for your consultation: _____
_____
_____

WHY DID YOU SELECT OUR CENTER? Please indicate all that apply:

( ) Patient Referral. May we ask who? _____ May we acknowledge referral? ( ) Yes ( ) No
( ) Doctor Referral. May we ask who? _____ May we acknowledge referral? ( ) Yes ( ) No
( ) General Reputation or Recommendation ( ) Speaking Engagement. Where? _____
( ) Magazine. Name? _____ ( ) Newspaper. Name? _____
( ) Yellow Pages. Which book? _____ ( ) Other _____

MEDICAL HISTORY

The medical history is an extremely important part of your consultation. It helps to alert us to any potential problems that might interfere with your surgery. Please take the time to fill this out completely and accurately. If you need some help, the staff will be glad to assist you.
Do you have an advanced directive or living will? ( ) Yes ( ) No. Would you like information? ( ) Yes ( ) No

List ALL prescription drugs you are taking: _____
_____
List ALL non-prescription drugs you take (I.E. aspirin, herbal medicines, etc.) _____
List ANY diet pills you take – VERY IMPORTANT! Can cause serious problems with anesthesia _____
List ANY drugs to which you are ALLERGIC _____
List ANY contact allergies including latex or other products _____

Please tell us about <u>ANY</u> serious illnesses you have had in the past: for example, heart disease, blood pressure problems, pulmonary disease, kidney disease, diabetes, thyroid trouble, stomach ulcers, etc. _____

_____

Please list any operations you have had (including cosmetic surgery) Give approximate dates: _____

_____

If applicable, please circle: Tubal ligation Hysterectomy Post-Menopausal
Describe <u>ANY</u> difficulties you have had with anesthesia _____
Describe <u>ANY MAJOR</u> injuries you have sustained (include dates) _____
Are there any hereditary disorders in your family that might be of significance? _____
Do you smoke? _____ If so, what form and how much? _____
Do you drink alcohol? Please check one: ( ) None ( ) Occasional ( ) Moderate ( ) Heavy _____
Do you now or have you ever had an addiction to controlled narcotics or street drugs? _____
How is your general health? ( ) Poor ( ) Fair ( ) Good ( ) Excellent
Are you under a doctor's care? _____ If yes, who? _____

Please review the list below and check anything applicable. If you check any of the boxes below, please use the space at the bottom for any explanation that you think would be helpful. Please be as complete as possible.

( ) Severe dryness of the eyes
( ) Recurrent severe dizziness
( ) Chronic sinus problems or nasal blockage
( ) Paralysis of the face
( ) Chronic hoarseness
( ) Chest pain
( ) Chronic abdominal problems
( ) Blood in bowel problems
( ) Bleeding disorders (you or anyone in your family)
( ) Menstrual disorder
( ) Problems with bones or joints
( ) Cancer
( ) Chronic skin condition
( ) Bad surgical result or unsatisfactory medical care
( ) Glaucoma or blurry vision
( ) Severe headaches
( ) Recurrent fever blisters
( ) Asthma or emphysema
( ) Shortness of breath
( ) Heart disease or high blood pressure
( ) Kidney or bladder problems
( ) Blood in urine or trouble urinating
( ) Easy bruising
( ) Abnormal lump or node
( ) Unexplained weight loss
( ) Emotional or psychological problems
( ) Complications after surgery

Please Explain: _____

_____

_____

_____

_____

I HAVE READ THIS FORM ENTIRELY AND HAVE COMPLETED IT FULLY AND ACCURATELY TO THE BEST OF MY KNOWLEDGE.

Date this form was completed _____ Patient Signature _____

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