

Consultation and Medical Questionnaire

The information requested below is essential in our comprehensive evaluation of your case. Please complete this form as completely as possible. This information will remain part of your confidential medical chart in our office and will not be released without your written authorization.

Today's Date: _____

Name: _____ Female _____
Male _____

Home Address:

_____ Street _____ City _____ State _____ Zip _____
Date of Birth: _____ Age: _____ Social Security Number: _____

Employer: _____ Occupation: _____

Business Address:

_____ Street _____ City _____ State _____ Zip _____
Phone Numbers: _____

_____ Home/Evening _____ Business/Day

Marital Status: (circle) S M D Sep Spouse's Name: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Spouse's Business Telephone: _____ Ages of Children: _____

How were you referred to us?

Which surgical procedures are you interested in?

Nasal Surgery	Eyelid Surgery	Face, Neck or Brow Lift	Breast Enlargement/Reduction
Hair Transplants	Protruding Ears	Laser or Chemical Peels	Chin or Cheek Implants
Scar Revision	Dermabrasion	Skin Lesions, Skin Cancer	Collagen or Botox
Liposuction	Lip Augmentation	Other _____	

What *specifically* would you like to see accomplished with the above procedure(s)?

When did you first consider having this surgery?

Is having this surgery your idea or was it someone else's suggestion?

What has prompted you to investigate this surgery at this particular time?

Have you consulted any other doctors about this? When?

Have you discussed this surgery with your family? YES/NO Are they supportive? YES/NO
Have you had previous surgery for appearance reasons? YES/NO When?

What was done?

Who performed the surgery?

Were you satisfied with the results? Please explain.

Has anyone in your family or a close friend had surgery for appearance reasons? YES/NO
What was done? _____ By whom?

Was their experience satisfactory?

Do you exercise regularly? YES/NO Please describe. _____

Have you had any significant weight change in the past 2 to 5 years? YES/NO
Describe: _____

Medical History

Primary Care Physician:

Name Address Telephone

When was your last physical exam?

Were any problems noted?

Are you allergic to any medications? (please list)

Are you on any medications? (please list)

Do you take aspirin, ibuprofen, or any other over-the-counter medications? YES/NO Please list _____

Do you take vitamins or any homeopathic remedies regularly? YES/NO Please list _____

HAVE YOU HAD IN THE PAST OR DO YOU CURRENTLY HAVE (CAREFULLY REVIEW, CHECK AND DATE):

LUNGS

- Bronchitis
- Emphysema
- Asthma/Wheezing
- Valley Fever
- Pneumonia
- TB (or Family History)
- TB Positive Skin/Sputum
- Cough/Cold
- Sleep Apnea
- Abnormal Chest X-Ray

• Other _____

HEART AND VASCULAR

- Heart Failure
- Abnormal EKG
- Angina/Chest Pain
- Rheumatic Fever
- Feet Swelling
- Murmurs
- Pacemaker
- Shortness of Breath
- High Blood Pressure
- Low Blood Pressure
- Mitral Valve Prolapse
- Irregular Heart Beat/Murmurs
- Circulation Problems

• Heart Attack(s) (Dates) _____

• Other: _____

GENITAL/URINARY

- Kidney Stones
- Prostate Problems
- Sexual Problems
- Kidney, Renal or Urinary Tract Disease
- Urinary Catheter

• Dialysis Last Date of Dialysis: _____

• Other: _____

GASTRO-INTESTINAL

- Jaundice
- Liver Disease
- Hiatal Hernia
- Recent Weight Loss
- Nausea/Vomiting
- Rectal Bleeding
- Ulcers
- Heart Burn
- Pancreatitis
- Gall Bladder Problems

Other: _____

BLOOD AND COAGULATION

- Anemia (Low Blood Count)
- Sickle Cell Disease
- Blood Clotting Abnormalities
- Transfusion (Blood/Plasma)
- Other
- Aids/HIV
- Bruising
- Hepatitis
- Easy Bleeding

NERVOUS SYSTEM

- Stroke
- Numbness/Weakness
- Fainting Spells/Blackouts
- Head/Neck Injury
- Seizures/Epilepsy
- Mental Health Problems
- Other
- Dizziness
- Convulsions
- Falls
- Forgetfulness
- Memory Loss
- Headaches

MUSCULO-SKELETAL SYSTEM

- Muscle/Joint Pain
- Chronic Back or Neck Trouble
- Unusual Muscle Weakness
- Muscular Dystrophy (or family history)
- Other:
- Arthritis
- Multiple Sclerosis

OTHER

- Sleeping Problems
- Thyroid Problems
- Glaucoma/Cataracts
- Skin Problems
- Hearing Loss: Rt ____ Lt ____
- Breast Feeding
- Other:
- Infection
- Diabetes
- Sweats/Chills
- Low Blood Sugar
- Cancer

Have you had any complication related to anesthesia? • Yes • No • General • Local

Describe reaction _____ Malignant Hyperthermia? • Yes • No

Family member with complications related to anesthesia? • Yes • No

Describe reaction _____

Yes No

• Do you use tobacco? • Cigarettes ___packs/day • Cigars • Pipe • Chew Quit When? ___ Years of use? ___

• Do you use alcohol? How much? _____ Last drink _____ • Recovering Alcoholic

• Do you use any recreational drugs?

• Dentures • Upper • Lower • Bridge • Fixed • Non-fixed • Caps • Loose or Chipped Teeth

• Contact Lens: • Soft • Hard • Extended Wear

• Hearing Aid: • Right • Left

• Prosthetic Devices: • Joint Replacements • Lens Implants • Right • Left • Other: _____

• Could you be pregnant? Date of Last Menstrual Period _____

LIST PREVIOUS SURGERIES/INJURIES/HOSPITALIZATIONS OR PROCEDURES (INCLUDE DENTAL): • NONE

WHEN		WHEN	
—	—	—	—
—	—	—	—
—	—	—	—
—	—	—	—
—	—	—	—

Medical History

(Circle appropriate response)

- Have you ever received Accutane treatment for your skin? YES NO
- Do you suffer from recurring fever blisters or cold sores? YES NO
- Are you frequently sick or ill? YES NO
- Do you worry about your health? YES NO
- Do you often feel depressed or unhappy? YES NO
- Do strange people or places make you afraid? YES NO
- Does criticism always upset you? YES NO
- Do you wish you had someone to advise you? YES NO
- Are you easily upset or irritated? YES NO
- Are you considered a nervous person? YES NO
- Have you ever consulted or considered consulting a psychiatrist? YES NO
- Have you ever received medical treatment for a nervous condition? YES NO
- Has any part of your body ever been paralyzed? YES NO
- Have you ever had a seizure or convulsion? YES NO
- Do you often have severe headaches or dizzy spells? YES NO
- Have you ever been dissatisfied with the treatment you received from a doctor or a dentist? YES NO
- Are there any reasons why you should not have an operation at this time? YES NO
(If "Yes", explain. _____)
- Do you understand that the objective of any surgery for appearance reasons is improvement in appearance, not perfection? YES NO
- Although an aesthetic surgeon always strives for the best possible surgical result for their patients, are you aware that the achievable surgical results are always limited by each patient's unique features, tissues and healing characteristics? YES NO

Signed _____

Date _____