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American Board of Plastic Surgery
 American Board of Facial Plastic Surgery
 American Board of Otolaryngology
 American Society of Plastic Surgeons
 American Society for Aesthetic Plastic Surgery
 American Association of Plastic Surgeons
 American Society of Maxillofacial Surgeons
 The Rhinoplasty Society

The Premier Experience in Cosmetic Surgery....

Patient Medical History and Data

Name _____ Date of Birth _____
 Address (Home) _____ Telephone _____
 Email _____ Cell Phone _____
 Your Occupation/Employer _____
 Address (Business) _____ Telephone _____
 Marital Status _____ Spouse's Name _____ Age(s) of Children _____
 Spouse's Occupation/Employer _____ Telephone _____
 Name of family members who are our patients _____
 How were you referred to us? _____
 In which surgical procedure(s) are you interested in?
 Rhinoplasty (nose) _____ Chin _____ Eyelids _____ Face/Neck Lift _____
 Chemical Peel _____ Dermabrasion _____ Scar Revision _____ Protruding _____
 Removal of Cysts, Warts, Moles, Etc. _____ Hair Transplant _____ Breast Surgery _____
 Body Contouring (tummy tuck) _____ Suction Lipectomy _____ Other _____
 What do you specifically wish to have corrected? _____
 Do you desire improvement in both appearance and function? _____
 When did you begin to consider surgical correction? _____
 Why have you decided to have it done at this point in time? _____
 Have you consulted any other doctor about this? If so, when? _____
 Have you discussed this surgery with your family? _____ Are they agreeable? _____
 Have you had previous cosmetic, plastic or reconstructive surgery? _____
 When and what? _____
 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? _____
 If so, when and describe it _____
 Has anyone in your family or a close friend had cosmetic, plastic, or reconstructive surgery? _____
 What was done and who performed the surgery? _____
 Have you had any other prior surgery? If so, when and who performed the surgery? _____
 Head and neck area? _____ Skin? _____
 Chest? _____ Abdomen? _____
 Teeth or gums? _____ Back, arms, or legs? _____
 Reproductive system? _____ Other? _____
 Were there complications? _____
 Did you have a normal recovery or any complications? _____
 Did the results meet your expectations? _____
 Yes / No Are you taking any drugs or medications?
 Names: _____
 Yes / No Are you allergic to any medication, cream, tape, make-up, etc.? Names: _____
 When was your last physical examination? _____ By whom: _____

Yes / No Have you ever received local anesthesia by a doctor or a dentist?

Yes / No Did you have a reaction? Please explain: _____

Yes / No Are you considered a healthy person? _____

Yes / No Do you take vitamins regularly? _____

Names: _____

Do you or any family member have:

Heart trouble _____ Excessive bleeding _____ Psychiatric or nerve problems _____

High Blood Pressure _____ Diabetes _____ Thyroid problems _____

Excessive bruising _____ Excessive Scarring _____ Delayed or poor healing _____

Do you have any history of: (Circle all that apply)

Bleeding from the nose _____ Blood in urine _____ Vomiting blood _____ Bleeding from rectum _____ Coughing up blood _____

Yes / No Do you have hay fever, nasal allergies, or asthma? Explain: _____

Yes / No Do you have or have you had any problems with your eyes or vision? Explain: _____

Yes / No Do you have frequent pains in your chest? _____

Yes / No Has a doctor ever said you had "heart trouble"? Explain: _____

Yes / No Do you have stomach problems or ulcers? Explain: _____

Yes / No Do you have or have you had chest or lung problems? Explain: _____

Yes / No Have you ever had liver, gall bladder, or yellow jaundice problems? Explain: _____

Yes / No Have you been bothered by kidney or bladder problems? Explain: _____

Yes / No Do you or any family members suffer from arthritis?

Yes / No Do you experience poor circulation in your fingers or toes?

Yes / No Do you have frequent skin irritations, infections, or rashes?

Yes / No Have you ever had fever blisters, cold sores, or canker sores on your face, lips, or mouth?

Yes / No Have you ever had genital herpes?

Yes / No Do you often have severe headaches or dizzy spells?

Yes / No Has any part of your body ever been paralyzed or numb? Explain: _____

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

Yes / No Have you ever received any type of treatment for you genital area? Explain: _____

Yes / No Have you ever been diagnosed with a venereal disease or AIDS? Explain: _____

Yes / No Are you frequently sick or ill?

Yes / No Do you worry about your health?

Yes / No Have you ever been treated for anemia or any problems with your blood? Explain: _____

Yes / No Have you ever taken hormones or thyroid medication? Explain: _____

Yes / No Do you smoke more than 10 cigarettes a day?

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

Yes / No Do you drink more than 2 alcoholic drinks a day?

Yes / No Have you ever been treated for abuse of alcohol or drugs? Explain: _____

Yes / No Do you often get depressed?

Yes / No Do you usually feel unhappy or depressed?

Yes / No Are you considered a nervous person?

Yes / No Have you ever had a nervous breakdown? Explain: _____

Yes / No Have you ever received treatment for a nervous breakdown? Explain: _____

Yes / No Are you easily upset or irritated?

Yes / No Do you tend to hold a grudge when someone angers you?

Yes / No Have you ever considered consulting a psychiatrist or psychologist? Explain: _____

Yes / No Have you ever had prostate problems? Explain: _____

Yes / No Do you have any other medical problems that have not been covered? Explain: _____

Yes / No Do you accept the fact that every medical/surgical treatment is associated with risks and unknowns?

Yes / No Do you consent to and authorize the recommended diagnostic, medical, surgical, anesthetic, and other diagnostic services that the clinic deems beneficial while you are under our care?

Signed: _____

Date: _____