Aesthetic Surgical Associates
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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....

Name _____ Date of Birth _____
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, gallbladder, 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 your 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 Have you had your Covid vaccine? Pfizer ___ Moderna ___ Johnson & Johnson ___
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: _____