COSMETIC SURGERY SPECIALISTS
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PLEASE PRINT and COMPLETE ALL INFORMATION Appointment date____________________

Patient Name:_____________________ _______ ______________________________
FIRST MI LAST

Address: ____
Street # & Name City State Zip

Date of Birth: _________________ Age: _____ Sex: _____M _____F

S.S. # _________________ S____M____D____W____ Spouse Name: _________________________
Marital Status

Telephone: Home #: _________________________ Cell#:_________________________________

May we call you at work? __Y __N Work #:_______________________________________

May we contact you by email? __ Y ___ N Email address: _______________________________

Your Occupation:_____________________Your Employer:_______________________________

Employer Address: ____

Emergency Contact Person: ____
Relationship: ____________________________Telephone:________________________

How did you hear about our office? ____

Family Physician: __________________________ Phone:______________Fax:______________
First Last

Address of Family Physician: ____
Street # & Name City State Zip

Referring Physician: _________________________ Phone: ______________ Fax:______________
(if other than family physician) First Last

Please list your reasons for this consultation:
____
____

Have you had previous surgery including cosmetic surgery? _____ YES _____ NO If yes, please list procedure(s):
____
____
____

Were there any complications? _____ YES _____ NO If yes, please list complications:
____
____

Have you or a family member had any problems with anesthesia? ____YES ____NO
If yes, please explain circumstances below:
____

Have you ever consulted or been treated by a psychiatrist or psychologist? ___YES ___NO
If yes, please explain circumstances below:
____

Are you, or might you possibly be pregnant? ___YES ___ NO ___ NOT APPLICABLE
Do you take blood thinners, aspirin or non-steroidal anti-inflammatories (NSAIDs)? __ YES __ NO
If yes, please list:____

Are you allergic to latex? ___YES ___NO
Are you allergic to any medications? ___YES ___NO If yes, please list: ____________________
____

List all medications you are presently taking including strength and how often:

1.________________________ ____________________mg __X a Day
2.________________________ ____________________mg __X a Day
3.________________________ ____________________mg __X a Day
4.________________________ ____________________mg __X a Day
5.________________________ ____________________mg __X a Day

(For additional medication, please use the back of this form)

Please list ALL vitamins, supplements, and/or herbs you are presently taking: ________________
____

Are you currently under treatment for alcohol or drug abuse? ___YES ___ NO
How much alcohol do you consume in one week? ___ None ___ Light ___ Moderate ___ Heavy
Do you presently smoke? ___ YES ___ NO If yes, amount per day _____ How long? __________
Have you ever smoked? ___ YES ___ NO If yes, amount per day _____ How long? __________
Have you ever had Tuberculosis (TB)? _____ YES _____ NO
Have you ever been exposed to Tuberculosis (TB) within the past year? _____YES _____ NO

Have you ever had or been treated for any of the following: (Please check all that apply)

_High blood pressure
_Stroke
_Rheumatic fever
_Mitral valve prolapse
_Congestive heart failure
_pacemaker/AICD
_palpations
_chest pain/pressure
_heart murmur
_heart attack/MI
_rheumatic fever
_Shortness of breath
_Bleeding disorder/blood/clot/DVT
_Weakness/numbness in a limb
_Epilepsy/seizure disorder

_Dizziness/passing out spells
_Neuritis
_Head injury
_Frequent or severe headaches
_Excessive tiredness/fatigue
_Pain shoulder/arms/hands
_Chills/fever/night sweats
_Anxiety
_Excessive worry/depression
_Difficulty in sleeping
_Allergy/hay fever
_Chronic cough/recent cold
_Emphysema/COPD/lung trouble
_Asthma/wheezing
_Sinus trouble

_Severe ear, nose, throat trouble
_prolonged hoarseness
_pneumonia
_Recent gain/loss of weight
_Coughing/vomiting blood
Indigestion/GERD/reflux
_Loss of appetite/nausea/vomiting
_Peptic/stomach ulcer
_Bladder infection
_Kidney stone/blood in urine
_Changes in bowel habit/bleeding
_Repeated diarrhea
_Constipation
_Frequent urination

_Swelling of ankles or feet
_Cataract/glaucoma
_double vision/blindness
_eye injury/disease
_arthritis/joint pain
_back problems/pain
_broken bones/bone disease
_gout
_skin rash/disease
_diabetes
_anemia
_thyroid problem
_liver disease/jaundice/hepatitis
_Aids/ARC

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FOR PHYSICIAN USE ONLY	By signing below, I attest I have reviewed the above information.
	Signature ____ Date __________