Today's date			
Last Name		First Name	
Date of Birth		Age	
Referred By			
Reason for today's visit			
Social Security Number			
Home Phone		Fax	
Cell		Email	
Can we contact you by email?	Yes No		
Your Street Address			
City	State	Zip Code	
Employer		Position	
Type or Name of Business			
Employer Address Street			
City	State	Zip Code	
Work Phone		Fax	
Email		Male	Female
Marital Status	Single Married	Divorced	Widowed
Weight		Height	
Brassiere Size		Waist	
Personal Physician		Physician's Phone	
Date of Last Physical Exam		Date of Last Skin Exam	
Pregnant	Yes No	Date of Last Menstrual Period	
Birth Control Pills	Yes No	Other Birth Control	Yes No
Do you have children?	Yes No	How many?	
Did you breast feed your children?	Yes No		
Were any of your children delivered by C-section?	Yes No	If yes, how many?	
Have you had a recent mammogram?	Yes No	Date	
Location		Results	

Skin

Do you visit a skin care salon on a frequent basis?	Yes No	
Do you use skin care products?	Yes No	
If yes, please list them.		
Do you routinely have any of the following skin therapies?	Please check all that apply	
	Microderm abrasion	Acid Peels
	Botox	Laser Treatments
	Thermage	Cool Touch

	Collagen/other fillers (lips, lines, etc)		Other	
How would you rate your skin health?	Excellent	Good	Fair	Need Skin Care
Do you have a dermatologist?	Yes	No		
If yes, give dermatologist's name				
Do you wear makeup?	Yes	No		
Any Allergies to Medications?	Yes	No		
If yes, please list the medications and your reactions to them.				
Any Allergies to Latex?	Yes	No	Tape?	Yes No
Other substances or materials you are allergic to, please list them.				
Medications				
Please list prescribed medications you are presently taking.				
Please list any over the counter medications you are presently taking				
Do you take Blood Thinners?	Yes	No	Aspirin?	Yes No
Exercise	Never	Sometimes	Moderate	Aggressive
Social History				
Smoke?	Yes	No	Former	Socially
How many packs/day?		How many years?		
Alcohol?	Every day	A few times a week	Socially	Never
Drugs?	Yes	No	Former	Drug
How long?				
Surgical History				
Any previous non-plastic surgery?	Yes	No		
Please list previous non-plastic surgeries and their dates if possible				
Do you tend to form thick scars?	Yes	No		
Please select Plastic Surgery procedures you have had.	Please check all that apply			
	Botox Treatments		Facelift	
	Browlift		Necklift	

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		Blepharoplasty (eyelid surgery)		Rhinoplasty (nasal surgery)
		Ear surgery		Lip Augmentation Surgery
		Lip Injections		Chin Implant
		Breast Augmentation		Breast Reduction
		Breast Lift		Breast Reconstruction
		Liposuction Trunk		Liposuction Arms/Legs
		Tummy Tuck		

Anesthesia History	
Any problems with anesthesia?	Yes No
If yes, please explain.	
Have you had malignant Hyperthermia with anesthesia?	Yes No
Has any family member had a problem with Malignant Hyperthermia?	Yes No

Medical History				
Please help us take better care of you by answering the following:	Please check all that apply			
		Diabetes		High Blood Pressure
		Chest Pain (at rest)		Chest Pain (at exertion)
		Shortness of Breath		Irregular Heartbeat
		Heart Murmur		Heart Valve Problem
		Emphysema		Heart Attack
		Bypass Surgery		Asthma
		Stroke or loss of consciousness		Seizures
		Facial Paralysis		Bell's Palsy
		Vertigo		Hearing Problems
		Thyroid Disease		Easy brusing/excessive bleeding
		Gums bleed after brushing teeth		Blood Clots
		Corneal Surgery (Lasik or similar)		Cataracts
		Glaucoma		Liver Disease
		Kidney Disease		Ulcers (stomach, intestinal)
		Oral Herpes (cold sores)		Vericose Veins
		Skin Disease		Skin Cancer
		Abnormal healing (keloids, thick scars)		
Any of the following conditions:	Please check all that apply			
		Breast Pain		Breast Lumps
		Breast Cancer		Cervical Cancer
		Ovarian Cancer		Uterine Cancer

Do you have any implants? (breast, joint/hip/knee, heart valve, dental or other)	Yes	No	
Please list them			
I need antibiotics prior to dental work	Yes	No	
Do you wear eyeglasses?	Yes	No	
Do you wear contact lenses?			
Do you have dry eyes?			
Do you have any dietary restrictions?			
Family Medical History			
	Please check all that apply concerning your family history		
	Breast Cancer	Cervical Cancer	
	Uterine Cancer	Ovarian Cancer	
	Colon Cancer	Melanoma	
	Skin Diseases	Birth Defects	
	Would healing problems	Blood Disorder	
	Heart Disease	Anesthesia (Malignant Hyperthermia)	
	Diabetes		
Emergency Contact			
Name		Phone	
Fax		Cell	
Email		Relationship	
Other Contact			
Name		Phone	
Fax		Cell	
Email		Relationship	

Signature of Patient or Guardian ____

Date

Would you like to participate in a clinical research study that may help better treat your condition?

Please check one Yes No

Please visit us at our website at www.drmplasticsurgery.com

We also encourage you to visit the The American Society of Plastic Surgery at www.plasticsurgery.org

All Board Certified Plastic Surgeons can be found here as well as a wealth of information on Plastic Surgery.

Thank you for taking the time to visit with us.