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MR#:

Please make every effort to fill out the information fully and accurately.
Your responses are held strictly confidential and are not shared.

Today's Date:

Name ______________________ ______________________
First Last

Address ____
Street & Apt # City State Zip

Home Phone ____________ Cell Phone ____________ Work Phone ____________

E-mail ____________

Preferred Method(s) of Contact: ❒ Home Phone ❒ Cell Phone ❒ Work Phone ❒ Email

Please do not contact me by: ____________

Age ______ Birthdate ____________ SS# ____________ Gender ❒ Female ❒ Male

Height ______ Weight ______ Number of Children ______

Highest Level of Education ❒ High School ❒ Some College ❒ College ❒ Masters ❒ Doctorate

Marital Status: ❒ Married: Spouse's Name: ____________ ❒ Single ❒ Separated/Divorced ❒ Widowed

If child, who may authorize treatment? Relationship:

Contact : First Name ____________ Last Name ____________ Relationship ____________

Home Phone Cell Phone Other Phone

Employer ____________ Occupation ____________

Address ____
Street & Suite # City State Zip

Spouse Employer ____________ Occupation ____________

Work Phone ____________

Address ____
Street & Suite # City State Zip

Please indicate your area(s) of interest:

NON SURGICAL	FACE	BREAST	BODY
❒ Botox	❒ Eyes - Blepharoplasty	❒ Breast Enlargement	❒ Liposuction
❒ Wrinkles	❒ Ears - Otoplasty	❒ Breast Implant Deflation	❒ Tummy Tuck
❒ Skin Filler	❒ Nose - Rhinoplasty	❒ Breast Implant Change	❒ Labiaplasty
❒ Lip Enhancement	❒ Facial Implant - Cheeks	❒ Breast Lift	❒ Arm Reduction
❒ Smile or Nasolabial Lines	❒ Facial Implant - Chin	❒ Breast Reduction	❒ Brazillian Butt Lift
❒ Skin Care / Enhancement	❒ Forehead/Brow Lift	❒ Male Breast Reduction	
❒ Obagi Blue Peel	❒ Facial Sculpting		
	❒ Necklift		
	❒ Facelift		
❒ Other	❒ Other	❒ Other	❒ Other

Please use this space to provide any other information you feel may be helpful to your consultation:

Procedure ______	Doctor ______	How long ago? ______
Procedure ______	Doctor ______	How long ago? ______
Procedure ______	Doctor ______	How long ago? ______
Procedure	Doctor	How long ago?

How did you hear about i g? **Patient** (Mark all that apply)

- ❒ ______ ______
- ❒ Radio: ______
- ❒ Email Promotion: ______
- ❒ Business: ______
- ❒ Website: ______
- ❒ Phonebook: ______
- ❒Magazine: ______
- ❒ Newspaper ______
- ❒ Event: ______
- ❒ TV Show: ______
- ❒ General Reputation
- ❒ Other: ______
- ❒ Friend/Relative:
- ❒ Doctor:

Medical History

Your medical history is an extremely important part of your consultation. It helps alert us to any potential conditions that may interefere with your surgery. Please take your time and fill this our as completely and accurately as possible. If you need any help or have questions, our staff will be happy to assist you.

List **All Prescription and *Non Prescription*** medications you are taking:

List any **Medical Conditions** you have or had:

List any **Surgery** you have had (including Cosmetic Surgery) **with dates**:

List any serious **Major Illness / Injury** you have had in the past:

List any **Diet Pills** you take (May cause problems with anesthesia):

List any **Drug Allergies**:

List any **Contact Allergies** (latex or other products):

Describe any difficulties you have had with **anesthesia**:

Breast Cancer Family History: Do you have:

❒ 2 or more relatives with breast cancer
❒ 2 or more relatives with ovarian cancer
❒ A relative with both breast and ovarian cancer
❒ A male relative with breast cancer
❒ A relative with got breast cancer before age 50
❒ An Ashkenazi Jewish heritage relative with breast or ovarian cancer

Do you Smoke? ❒ No ❒ Yes: What? ________________ How much per week? ________ How many years? ________

Do you drink Alcohol? ❒ No ❒ Occasionally ❒ 1-2 drinks daily ❒ 3 or more drinks daily

Do use any Recreational Drugs?

❒ No ❒ Yes: What? ________________________________ Times a Week? ________ How Many Years? ________

Are you or have you ever had an addiction to narcotics or recreational drugs?

❒ No ❒ Yes: What? ________________________________ Duration of use? ________ Date of last use: ________

How do you rate your general health? ❒ Poor ❒ Fair ❒ Good ❒ Excellent

Are you under a doctor's care? ❒ No ❒ Yes: Whom? ________________________________

Review the list below and check anything applicable. If you check any box, use the space below to explain further if needed.

❒ Chronic Skin condition	❒ Coughing up blood	❒ Blood in Urine or trouble urinating
❒ Severe drynes of the eyes	❒ Lung disease	❒ Bleeding disorders (you or family)
❒ Glaucoma or blurry vision	❒ Chronic hoarseness	❒ Blood clots (you or family)
❒ Wear Glasses/Contacts	❒ Heart Attack	❒ Menstrual disorder
❒ Drainage from ears	❒ Heart disease	❒ Easy bruising
❒ Difficulty Hearing	❒ Racing heart rate without cause	❒ Anemia
❒ Ringing in Ears	❒ High Blood Pressure	❒ Altered Thryoid hormone levels
❒ Recurrent severe dizziness	❒ Chest pain	❒ Diabetes
❒ Nasal Injury	❒ Swollen legs and ankles	❒ Low blood sugar
❒ Frequent Nose bleeds	❒ Stroke	❒ Always thirsty or urinating
❒ Difficulty Breathing from Nose	❒ Cancer	❒ Sensation changes
❒ Difficulty Smellling	❒ Abnormal lump	❒ Treated/Tested positive for Tuberculosis
❒ Chronic Sinus Infections	❒ Enlarged lymph node	❒ Treated/Tested positive for HIV
❒ Frequent Nasal Allergies	❒ Unexplained weight loss	❒ Treated/Tested positive for AIDS
❒ Chronic sinus/nasal blockage	❒ Problems with bones or joints	❒ Treated/Tested positive for Hepatitis
❒ Difficulty with Taste	❒ Arthritis	❒ Hospitalized for mental illness
❒ Recurrent fever blisters	❒ Joint Disease	❒ Emotional/Psychological concern
❒ Severe headaches	❒ Acid Reflux	❒ Under Psychiatric care
❒ Head Injury	❒ Stomach ulcers	❒ Alcoholism / Drug Addictions
❒ Paralysis (Face or Body)	❒ Chronic Abdominal problems	❒ Complications after surgery
❒ Shortnes of breath	❒ Yellow Jaundice or Hepatitis	❒ Bad/ unsatisfactory surgical outcome
❒ Sleep on pillows to help breathing	❒ Blood in Bowel movements / Stool	❒ **NONE OF THE ABOVE**
❒ Asthma or emphysema	❒ Kidney or bladder problems	❒ Other:________________________

Please explain:

I have read this form entirely and have completed it fully and accurately to the best of my knowledge.

Patient Signature **Date**

Date Reviewed