What would you like to achieve with Plastic Surgery?

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What Procedure are you interested in?

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What time frame are you considering? **1-3 months** **6-12 months** **Just need information**

Are you interested in financing? **YES** **NO**

Who may we thank for referring you? ____

MEDICAL INFORMATION:

Please check if you CURRENTLY HAVE any of these symptoms or check ( ) None

Constitutional:	Fever	Unexplained weight loss			
Gastrointestinal:	Nausea	Vomiting	Diarrhea	Constipation	Eating problems
Genitourinary:	Frequency	Burning	Difficulty	Irregular menstrual periods	
Endocrine:	Excess thirst	Hormone problems	Diabetes		
Lung/Respiratory:	Shortness of breath	Problem breathing	Asthma	Chronic Bronchitis	
Cardiovascular:	Chest pain	Palpitations	Ankle swelling	Heart disease	Prior heart attacks
Ear/Nose/Throat:	Hearing aid	Hearing problem	Ringing in ears	Ear infections	Problem swallowing
Pregnancy issues:	Currently pregnant	Planning pregnancy	Currently breast feeding		
Lymph/Hematology:	Abnormal bleeding	Swelling of glands	Clotting problems		
Eyes:	Contact lenses	Blurred vision	Vision problems		
Musculoskeletal:	Joint pain	Back pain			
Allergy/Immunology:	Seasonal allergies/Hay fever	Lupus	Autoimmune disease	HIV	
Neurological:	Migraines	Numbness	Seizures		
Psychiatric:	Depression	Anxiety			

Who is your primary care doctor? ____

Do you smoke? If so, how many packs per day? ________ Or per week_______

Do you drink alcohol? If so how many glasses a day? _____ Or per week ________

When was your last general exam? ______________________________________

Do you have any known allergies: If so, please list: ___________________________

Are you presently under psychological or psychiatric care? If so, please state therapist's name and length of treatment:

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Have you been under the care of any physician for any medical or surgical condition in the last 5 years? If so, please list physician and condition treated for:

____

____

Please list all surgery, including cosmetic surgery that you have had including the dates:

____

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Please list medications that you are currently taking. Including aspirin or ibuprofen. Please include dosages, frequency and the reason for taking the medication: ____

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Other Significant Medical Problems? ____

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