



PLASTIC SURGERY

PLASTIC SURGERY HISTORY AND INTAKE FORM

PATIENT NAME	EMAIL	PHONE
ADDRESS		OCCUPATION
CITY, STATE, ZIP		DOB
GENDER		

WHAT ARE WE SEEING YOU FOR TODAY?	HOW DID YOU HEAR ABOUT US?	SSN
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FACE	BREAST	BODY	SKIN
<input type="checkbox"/> Facelift <input type="checkbox"/> Cheek Lift <input type="checkbox"/> Brow Lift <input type="checkbox"/> Neck Lift <input type="checkbox"/> Facial Fat Transfer <input type="checkbox"/> Facial Implants <input type="checkbox"/> Lip Augmentation <input type="checkbox"/> Chin Augmentation <input type="checkbox"/> Ear Reshaping <input type="checkbox"/> Upper Eyelids <input type="checkbox"/> Lower Eyelids	<input type="checkbox"/> Rhinoplasty <input type="checkbox"/> Other: _____ <input type="checkbox"/> Breast Augmentation <input type="checkbox"/> Breast Lift (Mastopexy) <input type="checkbox"/> Breast Revision/Repair <input type="checkbox"/> Breast implant exchange <input type="checkbox"/> Breast Capsulectomy <input type="checkbox"/> Breast Reduction <input type="checkbox"/> Breast Asymmetry <input type="checkbox"/> Breast Reconstruction <input type="checkbox"/> Male Breast (Gynecomastia) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Liposuction <input type="checkbox"/> Tummy Tuck (Abdominoplasty) <input type="checkbox"/> Mommy Makeover <input type="checkbox"/> Body Lift <input type="checkbox"/> Buttock Augmentation <input type="checkbox"/> Arm Lift (Brachioplasty) <input type="checkbox"/> Thigh Lift <input type="checkbox"/> Fat Transfer/Brazilian Butt Lift <input type="checkbox"/> Other: _____	<input type="checkbox"/> Botox Cosmetic <input type="checkbox"/> Facial Fillers <input type="checkbox"/> Juvederm <input type="checkbox"/> Restylane/Perlane <input type="checkbox"/> Radiesse <input type="checkbox"/> Fat Injections <input type="checkbox"/> Skin Resurfacing/Laser <input type="checkbox"/> Hyperhidrosis <input type="checkbox"/> Skin Care <input type="checkbox"/> Latisse <input type="checkbox"/> Other: _____

PAST SURGERIES	DATE OF SURGERY

Medical History (please check all that apply)

Breast Cancer
 Do you have a family history of breast cancer? Yes No If so, which relative?
 Mother Father Sister Brother Daughter Son Uncle Aunt Nephew Niece Grandmother
 Grandfather Grandson Granddaughter Other _____

Malignant Hyperthermia and Anesthesia Sensitivity
 Do you have a family history of malignant hyperthermia or severe reactions to anesthesia? Yes No If so, which relative?
 Mother Father Sister Brother Daughter Son Uncle Aunt Nephew Niece Grandmother
 Grandfather Grandson Granddaughter Other _____

PRESENT MEDICATIONS

List any medications you are taking at this time. Include such items as aspirin, vitamins, laxatives, etc.

NAME OF MEDICATION	DOSE (Include strength and # per day)	NAME OF MEDICATION	DOSE (Include strength and # per day)
1.		4.	
2.		5.	
3.		6.	

Past Medical History - Select any of the following medical conditions you currently have (please check all that apply)

<input type="checkbox"/> Anxiety	<input type="checkbox"/> COPD	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Prostate Cancer
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Radiation treatment
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Hypercholesterolemia	<input type="checkbox"/> Seizures
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bone Marrow Transplant	<input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> BPH	<input type="checkbox"/> GERD	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Lymphoma
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Lasik
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Lymphoma	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> OTHER			

PLASTIC SURGERY HISTORY AND INTAKE FORM (page 2)

PATIENT NAME	DOB	AGE
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ALLERGIES (Please list ALL allergies)

Social History (please check all that apply)

<input type="checkbox"/> Currently smokes – daily	<input type="checkbox"/> Currently smokes – not daily	<input type="checkbox"/> Has Never smoked
<input type="checkbox"/> Has smoked in the past	<input type="checkbox"/> Drug use	<input type="checkbox"/> None
<input type="checkbox"/> Started Smoking (MM/DD/YYYY):	Quit Smoking (MM/DD/YYYY):	Number of packs per day: Total years Smoking:
<input type="checkbox"/> Not sexually active	<input type="checkbox"/> EtoH none	<input type="checkbox"/> Patient feels safe at home
<input type="checkbox"/> Sexually active with one partner	<input type="checkbox"/> EtoH less than 1 drink per day	<input type="checkbox"/> Patient feels unsafe at home
<input type="checkbox"/> Sexually active with more than one partner	<input type="checkbox"/> EtoH 1-2 drinks per day	<input type="checkbox"/> Other:
<input type="checkbox"/> IV drug use	<input type="checkbox"/> EtoH 3 or more drinks per day	
Driving status: <input type="checkbox"/> Drives in the Daytime <input type="checkbox"/> Drives at Night		How often do you exercise?
What is your caffeine use?	Occupation and Workplace:	
Place of Residence:		

Review of Systems: Are you CURRENTLY experiencing any of the following? (please check yes or no for the following)

Problems with bleeding <input type="checkbox"/> YES <input type="checkbox"/> NO	Bloody urine <input type="checkbox"/> YES <input type="checkbox"/> NO	Muscle weakness <input type="checkbox"/> YES <input type="checkbox"/> NO
Problems with healing <input type="checkbox"/> YES <input type="checkbox"/> NO	Blurry vision <input type="checkbox"/> YES <input type="checkbox"/> NO	Neck stiffness <input type="checkbox"/> YES <input type="checkbox"/> NO
Problems with scarring <input type="checkbox"/> YES <input type="checkbox"/> NO	Chest pain <input type="checkbox"/> YES <input type="checkbox"/> NO	Night sweats <input type="checkbox"/> YES <input type="checkbox"/> NO
Immunosuppression <input type="checkbox"/> YES <input type="checkbox"/> NO	Cough <input type="checkbox"/> YES <input type="checkbox"/> NO	Seizures <input type="checkbox"/> YES <input type="checkbox"/> NO
Changing Mole <input type="checkbox"/> YES <input type="checkbox"/> NO	Depression <input type="checkbox"/> YES <input type="checkbox"/> NO	Shortness of breath <input type="checkbox"/> YES <input type="checkbox"/> NO
Rash <input type="checkbox"/> YES <input type="checkbox"/> NO	Fever or chills <input type="checkbox"/> YES <input type="checkbox"/> NO	Sore throat <input type="checkbox"/> YES <input type="checkbox"/> NO
Abdominal pain <input type="checkbox"/> YES <input type="checkbox"/> NO	Headaches <input type="checkbox"/> YES <input type="checkbox"/> NO	Thyroid problems <input type="checkbox"/> YES <input type="checkbox"/> NO
Anxiety <input type="checkbox"/> YES <input type="checkbox"/> NO	Hay Fever <input type="checkbox"/> YES <input type="checkbox"/> NO	Unintentional weight loss <input type="checkbox"/> YES <input type="checkbox"/> NO
Bloody stool <input type="checkbox"/> YES <input type="checkbox"/> NO	Joint aches <input type="checkbox"/> YES <input type="checkbox"/> NO	Wheezing <input type="checkbox"/> YES <input type="checkbox"/> NO

Alerts (please check any that you have experienced)

<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Blood thinners	<input type="checkbox"/> West Africa: Travel or contact <input type="checkbox"/> Ebola Risk: Fever > = 100.4 degrees <input type="checkbox"/> Ebola Risk: Resided or Traveled to Country-wide spread Ebola transmission in last 21 days
<input type="checkbox"/> Defibrillator	<input type="checkbox"/> Pregnancy or planning a pregnancy	
<input type="checkbox"/> Artificial joints within past 2 years	<input type="checkbox"/> Allergy to lidocaine	
<input type="checkbox"/> Artificial heart valve	<input type="checkbox"/> Rapid Heart Beat with epinephrine	
<input type="checkbox"/> Premedication prior to procedures	<input type="checkbox"/> Yeast infections with antibiotics	<input type="checkbox"/> History of Cold Sores
<input type="checkbox"/> Allergy to adhesive	<input type="checkbox"/> GI upset with antibiotics	<input type="checkbox"/> History of Accutane
<input type="checkbox"/> Allergy to topical antibiotic ointments	<input type="checkbox"/> Other:	<input type="checkbox"/> Advanced Directive

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient/Representative Name (print) _____ Signature _____ Date _____