PHYSICIAN:_____

PLASTIC SURGERY HISTORY AND INTAKE FORM

PATIENT NAME	DOB	AGE

WHAT ARE WE SEEING YOU FOR TODAY?

FACE	BREAST	BODY	SKIN
□ Facelift □ Cheek Lift □ Brow Lift □ Neck Lift □ Facial Fat Transfer □ Facial Implants □ Lip Augmentation □ Chin Augmentation □ Ear Reshaping □ Upper Eyelids □ Lower Eyelids	□ Rhinoplasty □ Other: _____ _____ _____ _____ _____ _____ _____ _____ _____	□ Breast Augmentation □ Breast Lift (Mastopexy) □ Breast Revision/Repair □ Breast implant exchange □ Breast Capsulectomy □ Breast Reduction □ Breast Asymmetry □ Breast Reconstruction □ Male Breast (Gynecomastia) □ Other:_____	□ Liposuction □ Tummy Tuck (Abdominoplasty) □ Mommy Makeover □ Body Lift □ Buttock Augmentation □ Arm Lift (Brachioplasty) □ Thigh Lift □ Fat Transfer/Brazilian Butt Lift □ Other:_____	□ Botox Cosmetic □ Facial Fillers □ Juvederm □ Restylane/Perlane □ Radiese □ Fat Injections □ Skin Resurfacing/Laser □ Hyperhydrosis □ Skin Care □ Latisse □ 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)

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

PLASTIC SURGERY HISTORY AND INTAKE FORM (page 2)

PATIENT NAME	DOB	AGE

ALLERGIES (Please list ALL allergies)

Social History (please check all that apply)

□ Currently smokes – daily	□ Currently smokes – not daily	□ Has Never smoked
□ Has smoked in the past	□ Drug use	□ None
□ Started Smoking (MM/DD/YYYY):	Quit Smoking (MM/DD/YYYY:)	Number of packs per day: Total years Smoking:
□ Not sexually active	□ EtoH none	□ Patient feels safe at home
□ Sexually active with one partner	□ EtoH less than 1 drink per day	□ Patient feels unsafe at home
□ Sexually active with more than one partner	□ EtoH 1-2 drinks per day	□ Other:
□ IV drug use	□ EtoH 3 or more drinks per day	
Driving status: □ Drives in the Daytime □ 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 □YES □NO	Bloody urine □YES □NO	Muscle weakness □YES □NO
Problems with healing □YES □NO	Blurry vision □YES □NO	Neck stiffness □YES □NO
Problems with scarring □YES □NO	Chest pain □YES □NO	Night sweats □YES □NO
Immunosuppression □YES □NO	Cough □YES □NO	Seizures □YES □NO
Changing Mole □YES □NO	Depression □YES □NO	Shortness of breath □YES □NO
Rash □YES □NO	Fever or chills □YES □NO	Sore throat □YES □NO
Abdominal pain □YES □NO	Headaches □YES □NO	Thyroid problems □YES □NO
Anxiety □YES □NO	Hay Fever □YES □NO	Unintentional weight loss □YES □NO
Bloody stool □YES □NO	Joint aches □YES □NO	Wheezing □YES □NO

Alerts (please check any that you have experienced)

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

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

Patient/Representative Name (print)_____Signature_____Date_____