

Sunset Cosmetic Surgery

PERSONAL INFORMATION

Patient Name: _____ Today's Date: _____

Reason for Visit: _____

Date of Birth: ____/____/____ Age: ____ Sex: M / F Married / Single / Divorced

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Employer: _____ Work Phone: (____) _____

Occupation: _____ Fax: (____) _____

Email: _____ Check if you do not want occasional email updates.

PAST MEDICAL HISTORY

Prior Plastic Surgeries: _____

Prior Surgeries or Procedures: _____

Are you currently being treated for any medical condition(s), or have you been in the past? (Yes / No)

Please list: _____

Family History of Illnesses: _____

Current Medications: _____

Medication Allergies: _____ Easy Bruising or Bleeding: Yes / No

Personal Physician: _____ Phone: (____) _____

Date of Last Physical Exam: _____ By: _____

Ever Seen a Psychiatrist or Psychologist? _____ When? _____

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PATIENT HEALTH QUESTIONNAIRE

Height: _____ Weight: _____ Recent weight gain or loss: _____

Recent Chest X-Ray: (Y / N) Comments: _____

Recent EKG: (Y / N) Comments: _____

Recent Mammogram: (Y / N) Comments: _____

Smoking History: (Yes / No) If yes, please give daily amount: _____

Drink Alcohol: (Yes / No) If yes, please give daily amount: _____

Have you ever had a history of the following?:

Are you taking any of the following?:

Heart attack, stroke, rheumatic fever..... Y / N
High/low blood pressure..... Y / N
History of chest pain..... Y / N
Do your ankles swell..... Y / N
Do you get short of breath easily..... Y / N
Asthma..... Y / N
Hives, rashes or skin disorders..... Y / N
Fainting spells or seizures..... Y / N
Diabetes Y / N
Hepatitis, jaundice, cirrhosis..... Y / N
Stomach ulcers or heart burn..... Y / N
Arthritis..... Y / N
Kidney problems..... Y / N
Tuberculosis or persistent cough..... Y / N
Coughing up blood..... Y / N
Venereal disease..... Y / N
Emotional disorders..... Y / N
Excessive bleeding with prior surgery..... Y / N
Blood disorders or anemia Y / N
Tumors of the mouth, nose or throat..... Y / N

Antibiotics..... Y / N
Blood thinners..... Y / N
Diet pills..... Y / N
Steroids, NSAIDS..... Y / N
Aspirin, Motrin..... Y / N
Insulin..... Y / N
Heart medicine..... Y / N
Herbal supplements..... Y / N
Birth control pills..... Y / N
Hormone supplements..... Y / N

If yes to any of above, please list name and dose of medication(s):

Is there any reason you would not accept a transfusion in an emergency situation?... Y / N

If yes to any of the above, please elaborate:

Allergies and Sensitivities:

Local Anesthetics..... Y / N
General Anesthetics..... Y / N
Antibiotics (Penicillin)..... Y / N
Barbiturates, Sedatives..... Y / N
Morphine or Codeine..... Y / N
Adhesive Tapes..... Y / N
Latex..... Y / N

Signature of Patient, Parent or Guardian: _____

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EMERGENCY CONTACT INFORMATION

In case of an emergency notify: _____

Relationship: _____

Cell Phone: _____

Home Phone _____

I, the undersigned, represent that all of the information on this form is true and complete to the best of my knowledge and that I accept full financial responsibility for professional, medical and surgical services rendered.

Patient / Insured Signature: _____

Print Name: _____

REFERRAL INFORMATION

How did you first hear about us? Please check one.

One of our patients: _____

Another Doctor: _____

Magazine Advertising or Article: _____

Online: Search Engine(s) (eg. Google or Yahoo – please list) _____

Online: Other site(s): Implantinfo by Nicole Other Site (please list): _____

Online Yellow Pages: Yahoo Yellow Pages Superpages.com Yellowpages.com Not Sure

Yellow Pages/Phone Book

Television: _____

Other (please explain): _____