

# Sunset Cosmetic Surgery

## PERSONAL INFORMATION

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Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Reason for Consultation: \_\_\_\_\_

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

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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

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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

### 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

If yes to any of the above, please elaborate:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Patient, Parent or Guardian: \_\_\_\_\_

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## EMERGENCY CONTACT INFORMATION

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In case of an emergency, please 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

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

One of our patients: \_\_\_\_\_

Another Doctor: \_\_\_\_\_

Magazine Advertising or Article: \_\_\_\_\_

Online: Search Engine(s) (e.g. Google or Yahoo – please list) \_\_\_\_\_

Online: Other site(s): Implantfinfo 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): \_\_\_\_\_

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## Personal Health and Beauty Questionnaire

Please check all issue that may be of concern to you. This information will not be shared with anyone.

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### Overall health and body concerns:

- |   |   |
|---|---|
| <input type="checkbox"/> Always tired and too little energy | <input type="checkbox"/> Don't feel as sexy or sexual as I want |
| <input type="checkbox"/> Wish to lose weight                | <input type="checkbox"/> Improve mental clarity and sharpness   |
| <input type="checkbox"/> Wish my mood was better            | <input type="checkbox"/> Wish I had better sleep                |

### Facial Aging & Expressions

When looking at my face in the mirror, I believe I look:

- Younger than my true age.
- About right for my age.
- Older than my true age.

When looking in the mirror, I am:

- Not concerned about wrinkles.
- Somewhat concerned about the appearance of my wrinkles.
- Very concerned about the appearance of my wrinkles.

- |  |   |
|--|---|
| <input type="checkbox"/> Desire more youthful skin                         | <input type="checkbox"/> Wish to enhance eyelashes or brows |
| <input type="checkbox"/> Tired eyes  | <input type="checkbox"/> Hyperpigmentation or Melasma       |
| <input type="checkbox"/> Sagging skin, jowls, neck                         | <input type="checkbox"/> Sun damage                         |
| <input type="checkbox"/> Wrinkles  | <input type="checkbox"/> Age spots                          |
| <input type="checkbox"/> Face gaunt or hollow                              | <input type="checkbox"/> Facial veins                       |
| <input type="checkbox"/> Chubby or "chipmunk" cheeks                       | <input type="checkbox"/> Weak chin/jaw                      |
| <input type="checkbox"/> Facial expression<br>[too old, sad, angry, tired] | <input type="checkbox"/> Improve appearance of Nose         |
| <input type="checkbox"/> Heavy brow  | <input type="checkbox"/> Ears too prominent                 |
| <input type="checkbox"/> Acne  | <input type="checkbox"/> Lips not as attractive as before   |
|  | <input type="checkbox"/> Other _____                        |

### Breast Size/Shape

- |   |  |
|---|--|
| <input type="checkbox"/> Too small          | <input type="checkbox"/> Too saggy           |
| <input type="checkbox"/> Too big            | <input type="checkbox"/> Nipple size         |
| <input type="checkbox"/> Uneven             | <input type="checkbox"/> Not enough cleavage |
| <input type="checkbox"/> Unattractive shape | <input type="checkbox"/> Other _____         |

### Body Size/Shape/Contours

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Abdomen – Stomach – Waistline | <input type="checkbox"/> Arms        |
| <input type="checkbox"/> "Love handles"                | <input type="checkbox"/> Buttocks    |
| <input type="checkbox"/> Thighs – Legs – Calves        | <input type="checkbox"/> Other _____ |

### Other Services

- Leg veins or spider veins
- Eliminating underarm sweating
- Eliminating sweaty palms