Sunset Cosmetic Surgery

PERSONAL INFORMATION

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

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?:

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 seizes……..… 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

If yes to any of the above, please elaborate:

_____
_____
_____
_____

Are you taking any of the following?:

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

Signature of Patient, Parent or Guardian: _____

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www.SunsetCosmeticSurgery.com

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EMERGENCY CONTACT INFORMATION

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

How did you <u>first</u> hear about us? Please check one.

☐ One of our patients: _____

☐ Another Doctor: _____

☐ Magazine: NewBeauty Magazine Other (please list): _____

☐ Online: Search Engine(s) (e.g. Google, Yahoo, Bing – please list) _____

☐ Online: Other site(s): YELP Real Self Other (please list): _____

☐ Television: _____

☐ Other (please explain): _____

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Personal Health and Beauty Questionnaire

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

Overall health and body concerns:

- ☐ Always tired and too little energy
- ☐ Wish to lose weight
- ☐ Wish my mood was better
- ☐ Don't feel as sexy or sexual as I want
- ☐ Improve mental clarity and sharpness
- ☐ 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.

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

Breast Size/Shape

- ☐ Too small
- ☐ Too big
- ☐ Uneven
- ☐ Unattractive shape
- ☐ Too saggy
- ☐ Nipple size
- ☐ Not enough cleavage
- ☐ Other_____

Body Size/Shape/Contours

- ☐ Abdomen – Stomach – Waistline
- ☐ "Love handles"
- ☐ Thighs – Legs – Calves
- ☐ Body lift
- ☐ Arms
- ☐ Buttocks
- ☐ Mommy makeover
- ☐ Other_____

Other Services

- ☐ Leg veins or spider veins
- ☐ Injectables
- ☐ Eliminating sweaty palms
- ☐ Cellulite
- ☐ Scar elimination/revision
- ☐ Eliminating underarm sweating