

CONSULTATION INFORMATION

Name _____ Age _____ Date _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

Home phone _____ Work phone _____

At what telephone number can we best reach you? _____

What cosmetic procedure(s) are you considering? Please check all that apply.

- Liposuction Tummy Tuck Male breast reduction
 Breast Augmentation Breast lift Implant Revision &/or replacement
 Facelift Forehead lift Eyelid Surgery Necklift
 Skin Rejuvenation Acne Scar or other scar improvement Botox/Dysport
 Facial Fillers Laser resurfacing
 Other _____
 Not certain – To discuss with doctor Private – To discuss with doctor

How did you hear about us?

- Arizona Republic Magazine Internet Newspaper TV Gym Saw our sign
 Patient Referral Who? _____ Other _____

Please list any allergies to medications you have.

Please list any medical conditions you have – **heart disease, hypertension, kidney disease, cancer, diabetes, hepatitis, seizures, etc.**

Please list any cosmetic surgeries you have had.

Please list any surgeries other than cosmetic surgeries you have undergone.

Please list all medications with dosages that you are currently taking.

If you are female, how many pregnancies to term have you had? _____

Do you take any of the following, regularly, two times a week or more?

Aspirin Yes No (including 81mg Aspirin)

Ibuprofen (Advil, Motrin) Yes No Aleve Yes No

Coumadin Yes No Prednisone Yes No Methotrexate Yes No

Humira Yes No Vitamin E and/or Fish Oil Yes No

Do you have any blood or blood clotting disorders? Yes No

If yes please describe _____

Do you smoke cigarettes on a daily basis? Yes No

If yes, how many cigarettes/day _____

Do you drink more than 2oz of alcohol/day? Yes No

Do you have any trouble swallowing pills? Yes No

Have you had outbreaks of oral herpes in the past (cold sores around the mouth)? Yes No

Are you HIV positive? Yes No

Are you Hepatitis B positive? Yes No

Are you Hepatitis C positive? Yes No

Have you ever had MRSA (Methicillin Resistant Staphylococcal infection)? Yes No

If yes, to any of the above, what is your current status (virus free, cured, taking meds)?

Have you had any problems with anesthesia in the past? Yes No

If yes, what happened and with what agent?

Can you take morphine? Yes No

Can you take demerol? Yes No

Can you take epinephrine? Yes No

Do you have dry eyes Yes No

Do you have lens implants in your eyes Yes No

Have you ever been told you had an adhesive allergy? Yes No Allergy to tape? Yes No

Latex allergy? Yes No

Do you have sleep apnea? Yes No

If yes, do you wear CPAP at night? Yes No

Have you ever had a blood clot in you calf? Yes No

Have you ever had a blood clot(s) that went to your lungs (pulmonary embolus)? Yes No

If yes to either, when? _____

Do you have advance directives (living will, medical power of attorney)? Yes No