PEORIA COSMETIC SURGERY
Shaili Gal, MD

PATIENT INFORMATION

Shaili Gal, MD
15396 N. 83rd Ave. Bldg. A Suite 301
Peoria, AZ 85381

Name ______________________________________ Date_________________

D.O.B. ____________________ Age:________ ☐Female ☐Male

Address ____

City _____________________________ State _________ Zip ____________

Home tel. _________________ Work tel. _________________ Cell _______________

*(Please **circle** the telephone number above at which **you prefer** to be contacted.)*

Email Address ____

☐ Married ☐ Single Occupation ___________________________________

Employer ____

In case of emergency contact ____

Relationship ☐Spouse ☐Significant Other ☐Parent ☐Son/Daughter ☐Other Relative ☐Medical power of Attorney ☐ Friend

Home tel. _________________ Work tel. ______________ Cell ______________

Pharmacy__________________ Phone__________________ Cross Streets________________

Health Insurance ☐ Private ☐ Group ☐HMO ☐ Medicare ☐None

Name & Address of Carrier ____

Policy # ____

**(Providing our office with your health insurance information is optional and for emergency use only. The Cosmetic surgical procedures we perform are not usually covered by your health insurance.)*

Do you have Advance Directives (Living Will and/or Health Care Power of Attorney)? ☐Yes ☐No

What is your preferred Social Media Platform? ☐Instagram ☐Twitter ☐YouTube ☐Facebook

What is your preferred method of contact? ☐Phone Call ☐Text Message ☐Email

PEORIA COSMETIC SURGERY
Shaile Goel, MD

CONSULTATION INFORMATION

Name ____ Date _______________

D.O.B.____________________ Age:_____________

Address ____City _________________

State ______ Zip _____________Email __________________________@____________

Cell Phone ______________________Home phone ________________________

Work phone ________________________ **Circle** which 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 ○ Ears ○ ThermiVa
○ Other ____
○ Not certain – To discuss with doctor ○ Private – To discuss with doctor

How did you hear about us?

○ 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 your 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