HIGHLY ARTISTIC PLASTIC SURGERY

CONSULTATION AND MEDICAL HISTORY/DATA

Name ____Date of Birth ________________________Today's Date________________________

Address: Home ____

Street City State Zip Telephone

Business____

Street City State Zip Telephone

Email ____Cell Phone __ (_____)

____

Marital Status: S, M, D, Sep., Widowed Spouse's name ______________________________ Age(s) of Children _________________________

Your Occupation / Employer _________________________________ Spouse's Occupation / Employer __________________________________

How were you referred to us? _______________________________ Name of family members who are our patient's_______________________

IN WHICH SURGICAL PROCEDURE(S) AND/OR LIFE ENHANCEMENT SERVICE ARE YOU INTERESTED?

Rhinoplasty (nose) _____ Chin _____ Face or Neck Lift _____ Eyelids _____ Chemical Peel _____ Dermabrasion _____ Scar revision _____

Protruding Ears _____ Removal of Cysts, Warts, Moles, Etc. _____ Breast Surgery _____ Body Contour Surgery (tummy tuck) _____

Suction Lipectomy _____ Weight Management _____ Professional Skin Care _____ Injectible Fillers/Botox _____ Nutritional Counseling, including Nutritional Supplementation _____ Hormone Modulation Therapy _____ Teeth Whitening/Cosmetic Dentistry _____ Health Testing ___

Other ____

What specifically, do you wish to have corrected: (i.e. what don't you like about the above condition(s)? ______________________________

____

When did you begin to consider surgical correction? ___________Have you discussed this surgery with your family? Y/N Are they agreeable? Y/N

Why have you decided to have it done at this point in time? ____

Have you consulted any other doctor about this? **Y / N** When: ____

Have you had previous cosmetic, plastic or reconstructive surgery? **Y / N** When, and what was done? ____________________________________

____

Who performed the surgery? _________________________________ Where was it performed: ____

Were you satisfied with the results: ___________________________ If not, why? ____

Have you had ***any other surgery***, or an injury, to the face? Nose, Neck or Eyes? ____

When? ____ Describe, as best you can ____

Has anyone in your family or a close friend had cosmetic, plastic or reconstructive surgery? ____

What was done? ____ By whom? ____

Have you had any other prior surgery? (What was done & when was it performed?) In the head & neck area? _____________________________

On your skin? _________________ On your teeth or gums? _______________ In your chest? ________________ in your abdomen? ___________

On the reproductive system? ________________________________ On your back, arms, or legs? _________________ Other: _________________

Were there complications? **Y / N** Did you have a normal recovery? **Y / N**

Did the results meet your expectations? ____________________ Please explain ____

MEDICAL HISTORY (circle appropriate response)

No / Yes Are you now taking any drugs or medications, including hormone replacement therapy, vitamins, nutritional supplements, green tea, herbs, etc? List them if you can ____

No / Yes Are you allergic to any latex, medication, creams, tape, make-up, etc.? List them if you can ____________________________________

____

When was your last physical examination? ____

Who is your family doctor? ________________________________Address ____

City ____________________________________State________________________________Telephone_________________________________

No / Yes Would you object to our contacting him/her for additional information pertaining to your health?

(Continued on back)

MEDICAL HISTORY (Continued)

No / Yes Have you ever received local anesthesia ("Novocain, Xylocain" etc.) by a dentist or doctor? (Circle appropriate response)
No / Yes Did you have a "reaction" to any anesthesia? Explain ______________________________
No / Yes Are you considered a healthy person?
No / Yes Do you take vitamins/ nutritional supplements regularly? Explain ______________________________

Do you or any family members have: (indicate who)

Heart trouble ____________ Excessive bleeding tendencies ____________ Psychiatric or "nerve" problems ____________
High blood pressure ____________ Diabetes ____________ Thyroid problems ____________
Excessive bruisability ____________ Excessive scarring ____________ Delayed or poor healing ____________

Do you have any history of bleeding: (indicate which)

From the nose ____________ In the Urine ____________ Vomitting blood ____________
From the rectum ____________ Coughing up blood ____________ Other? ____________

No / Yes Do you have hay fever, nasal allergies or asthma? Explain ______________________________
No / Yes Have you (or a member of your family) experienced swelling of the tongue and throat that caused difficulty with breathing? ____________
Explain ______________________________
No / Yes Do you have (or have you had) any problems with your eyes or vision? Explain ______________________________
No / Yes Do you have frequent pains in the chest or tire easily from exercise?
No / Yes Has a doctor ever said you had "heart trouble"? Explain ______________________________
No / Yes Do you have "stomach trouble" or ulcers? Explain ______________________________
No / Yes Do you have (or have you had) chest or lung problems? Sleep Apnea? Explain ______________________________
No / Yes Have you ever had liver, gall bladder trouble, "yellow jaundice", or hepatitis? Circle which one(s)
No / Yes have you been bothered by kidney or bladder problems? Explain ______________________________
No / Yes Do you or any family members suffer from "arthritis" or autoimmune conditions (lupus, scleroderma, etc)?
No / Yes Do you ever experience poor circulation in your fingers or toes?
No / Yes Do you have frequent skin infections, irritations or rashes? Circle which one(s)
No / Yes Have you ever had fever blisters or "cold sores" or canker sores on your face, lips or in your mouth? Circle which one(s)
No / Yes have you been bothered by genital herpes?
No / Yes Do you often have severe headaches or dizzy spells? Circle which one(s)
No / Yes Has any part of your body ever been paralyzed or numb? Explain ______________________________
No / Yes Did you ever have a convulsion or seizure? Explain ______________________________
No / Yes Have you ever received treatment for your genital or reproductive area? Explain ______________________________
No / Yes Were you ever told you had any venereal disease or AIDS? Explain ______________________________
No / Yes Are you frequently sick or ill?
No / Yes Do you worry about your health?
No / Yes Were you ever treated for anemia or any problems with your blood? Explain ______________________________
No / Yes Have you ever taken hormones or thyroid medication? Explain ______________________________
No / Yes Do you smoke or use nicotine in any fashion (patches, gum, etc)?
No / Yes Do you usually take two or more alcoholic drinks a day?
No / Yes Have you ever received treatment for abuse of alcohol or drugs? Explain ______________________________
No / Yes Do you often get depressed or blue?
No / Yes Do you usually feel unhappy, depressed, or tired?
No / Yes Are you considered a nervous person?
No / Yes Did you ever have a "nervous breakdown"? Explain ______________________________
No / Yes Are you easily upset or irritated?
No / Yes Do you tend to hold a "grudge" when someone angers you?
No / Yes Have you ever considered consulting a psychiatrist, psychologist or counselor? Explain ______________________________
No / Yes have you ever been under the care of a psychiatrist or psychologist? Explain ______________________________

If you are a woman, are you still having periods? Yes / No Are they often irregular? Yes / No
If you are a man, have you ever had prostate problems? Yes / No

If you have any other health problems that have not been covered, please explain: ______________________________
____

No / Yes Do you accept the fact that every medical and surgical treatment is associated with risks and other imponderables?
No / Yes Have you read our patient reference, "Highly Artistic Surgery Instruction Book" including the patient's Bill of Rights/Responsibilities?
No / Yes Do you agree to comply with the pre and post treatment instructions while you are under our care?

Signed ______________________________ Date ______________________________

Thank you for your confidence. The information you have provided is essential in our comprehensive evaluation in your case. Please re-read the "Highly Artistic Surgery Instruction Book" and write down any questions you may have so that we may discuss them in detail prior to treatment and/or surgery. If you do not have the book, please ask for one. You may also download the entire book at www.highlyartistic.com. It is an important part of informing you about your surgery.