## Cosmetique Plastic Surgery, Inc

Today's Date: ________________

Name: ______________________________________________
Last First M.I.

Local Address: ______________________________________
______________________ zip code_________

Permanent Address: ___________________________________
___________________ zip code_________

Telephone: H___________ Wk____________ Cell/bpr___________

Birth date:__________ Sex: M F Marital Status: M S W D Sep.

Occupation:______________________ Employer: _________________

Reason for consultation: ______________________________________

How were you referred to us? __________________________________

Have you seen other surgeons for this? Who? When? _______________
_________________________________

PATIENT SIGNATURE ________________________

# Cosmetique Plastic Surgery, Inc.

## Medical Information

1. Reason for consultation______________________________________________

2. List all previous surgeries/hospitalizations, including reason — General Anesthesia?

| Surgery/Hospitalization/Reason | Y/N |
|---|---|
| | |
| | |
| | |
| | |

3. List all medications you are taking, including eye drops and ointments

| Medication | Dosage | How often |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

4. Check any of the following diseases which you have or have had

| | | |
|---|---|---|
| ___Emphysema | ___High/Low Blood Pressure | ___Tuberculosis |
| ___Asthma | ___Heart Murmur | ___Cancer |
| ___Bronchitis | ___Irregular/Fast Heartbeat | ___HIV/Aids |
| ___Pneumonia | ___Seizure Disorder/Epilepsy | ___Angina |
| ___Stroke | ___Congenital Heart Disease | ___Rheumatic Fever |
| ___Glaucoma | ___ Excessive Bleeding | ___Thyroid Disorder |
| ___Diabetes | ___ Heart Attack | ___Dry Eye Syndrome |
| ___Skin Cancer | ___Nervous Breakdown | ___Psychiatric Care |
| ___Cataracts | ___Liver Disease/Hepatitis/Jaundice | |

5. FAMILY HISTORY: List immediate family members, either deceased (with cause of death and age) or living with serious illness.

______________________________________________

______________________________________________

______________________________________________

Any family history of breast cancer? Yes___ No___ If yes, who?______________________

______________________________________________

Patient Signature:______________________________

6. SOCIAL HISTORY: Please check and answer all of the following:

| Y | N | |
|---|---|---|
| | | Do you have any skin problems? If yes, please describe: |
| __ | __ | Rash ________ |
| __ | __ | Bruising ________ |
| __ | __ | Other ________ |
| __ | __ | Do you smoke? If yes, how many per day? ________ |
| __ | __ | Are you a former smoker? If yes, when did you stop? ________ |
| __ | __ | Do you drink alcoholic beverages? If yes, how much per day? ________ |
| __ | __ | Do you have vision problems? If yes, please explain: ________ |
| __ | __ | Do you wear eye glasses? |
| __ | __ | Do you wear contact lenses? |
| __ | __ | Do you wear a removable dental appliance/denture? |
| __ | __ | Do you now, or have you ever used "street drugs"? |
| __ | __ | Do you have allergies to medications or environment? If yes, explain: ________ |
| __ | __ | Do you have breathing problems? If yes, explain: ________ |
| __ | __ | Do you have any disease, condition, or problem not listed that you think the doctor should know about? If yes, explain: ________ |

7. PRIVATE/PERSONAL PHYSICIAN: ________

Phone Number: ________

Address: ________

Date of last exam: ________

Date of last EKG: ________

Last known blood pressure: ________

Date of last Mammogram: ________

I have read (or have had read to me) the above medical information listing and I hereby certify that the information I have provided is correct.

Signed: ________ Date: ________