

**Cosmetique Plastic Surgery Center**  
**Robert H. Hunsaker, M.D.**

**Full Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Personal E-Mail:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

**Cellphone:** \_\_\_\_\_ **2nd phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Marital Status:** M / S / D / W / Sep      **Sex:** M / F / M-F TG / F-M TG

**Emergency Contact: Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **2nd phone:** \_\_\_\_\_

**Referred by:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Cosmetique Plastic Surgery Center**

**Medical/Surgical History**

Reason for consultation: \_\_\_\_\_

Previous surgeries/hospitalizations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you EVER had any of the following?:

Asthma \_\_\_ Stroke \_\_\_ Glaucoma \_\_\_ Diabetes \_\_\_ Skin cancer \_\_\_

Cataracts \_\_\_ High blood pressure \_\_\_ Heart murmur \_\_\_ Cancer \_\_\_

Irregular/fast heartbeat \_\_\_ Heart attack \_\_\_ Seizures \_\_\_

Excessive bleeding \_\_\_ Hepatitis/Liver disease \_\_\_ Thyroid \_\_\_

HIV \_\_\_ Dry eyes \_\_\_ Psychiatric care \_\_\_

Is there any family history of breast cancer? Y / N

Signature: \_\_\_\_\_

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Please answer the following:

Y      N

-      —      Do you smoke tobacco?

—      —      Do you smoke marijuana?

—      —      Did you use to smoke?

—      —      Do you have any allergies to medicines?  
If yes, list: \_\_\_\_\_

—      —      Are you allergic to latex/Iodine on the skin/tape?

—      —      Do you wear glasses or contact lenses?

—      —      Do you have any removable dental appliances/dentures?

—      —      Have you used any "street drugs" in the past 6 months?

—      —      Do you have sleep apnea or snore?

—      —      Do you have any other medical problems not listed?

Signature: \_\_\_\_\_