Arizona Center for Aesthetic Plastic Surgery
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Certified, American Board of Plastic Surgery

Please complete all items and print

Date_____

Name_____ Sex_____ Age_____ Date of birth_____

How were you referred here? Internet____ Yellow Pages____ Physician____ Patient____ Family____ Friend____ Insurance____
Self____ ASPS____ Other____ None____ Name of Referral or Website_____

PLEASE DESCRIBE THE REASONS FOR YOUR CONSULTATION. (Include all relevant information)

_____

_____

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MEDICAL HISTORY

Height_____ Weight_____ Ideal weight_____ Have you been trying to lose weight? Yes_____ No_____

Any weight loss? Yes_____ No_____ How much?_____ Over what period of time? _____

Have you ever smoked? Yes____ No_____ If yes, do you still smoke? Yes_____ No_____ How many packs per day? _____

At what age did you start?_____ At what age did you stop?_____

Do you drink alcohol? Yes_____ No_____ What and how much?_____

Do you use recreational drugs? Yes_____ No_____ If yes, drug and frequency_____

Have you ever had Hepatitis? Yes_____ No_____ If yes, when?_____

Do you have AIDS or are you at high risk for acquiring AIDS? Yes_____ No_____

Will you have an AIDS test if surgery is planned? Yes_____ No_____

Have you had anesthesia previously? Yes_____ No_____ If yes, any problems? Yes_____ No_____

If yes,what?_____

PREVIOUS COSMETIC PROCEDURES (Please list)

Operation Year Surgeon's Name

_____

_____

_____

_____

_____

_____

(continued - please complete the back side of this form)

OTHER PREVIOUS SURGICAL PROCEDURES (Please list)

Operation Year

_____

_____

_____

_____

_____

MEDICAL ILLNESSES

Type Treatment, if any:

_____

_____

_____

_____

_____

MEDICATIONS (List all medications and dosages including pain relievers, aspirin, birth control pills and steroids.)

_____

_____

_____

_____

_____

_____

Do you have allergies to any medications? Yes_____ No_____ If yes, please list below:

Name of medication Type of Reaction

_____

_____

_____

_____

_____

SYSTEM REVIEW

Have you had problems with any of the following? (If yes, check which ones.)

_____ Abnormal scars or keloids
_____ Burning eyes
_____ Blurred/Double Vision
_____ Glaucoma
_____ Asthma
_____ Nose Bleeds
_____ Sinus Problems
_____ Shortness of Breath
_____Diabetes
_____Chest Pain
_____Palpitations
_____High Blood Pressure
_____Headaches
_____Bleeding Problems
_____Stomach Pain
_____Stomach/Duodenal Ulcer
_____Liver Problems
_____Yellow Skin
_____Burning when urinating
_____Numbness and tingling in hands
_____Arthritis
_____Seizures
_____Emotional/psychiatric problems

MATERNAL HISTORY (Women)

Have you ever been pregnant? Yes_____ No_____ How many times?_____ Number of children_____

Are you pregnant now? Yes_____ No_____ Are you planning more children? Yes_____ No_____

FAMILY HISTORY

Diabetes_____ Skin Cancer_____ Breast Cancer_____ Problems with anesthesia_____ Bleeding problems_____