Name: ______________________________ **Date of Birth:** ____________

Cosmetic New Patient Information Form

What features of your face or parts of your body would you like to improve? ________________

____

____

How did you find out about our practice? ____________________________________

If you have pain associated with your reason for visiting us today, please circle the description that is most appropriate:

sharp throbbing dull aching burning stabbing heavy

Circle the number corresponding to the intensity of your pain or symptoms (1 is no pain and 10 is the worst pain imaginable)

1 2 3 4 5 6 7 8 9 10

Circle all that apply: Is your pain getting:

better better gradually better rapidly getting worse worse gradually worse rapidly

What improves your symptoms? ____

What makes your symptoms worse? ____

Please list the specialists that you see: _____________________________________

Please list any surgeries / liposuction: ☐ None

Date	Surgery	Date	Surgery

Any problems with anesthesia? Yes No If yes, explain_____________________________

Please list any Medical Diagnosis (fill in blanks or circle in list below or both):

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

- Anxiety, depression, mental or nervous disorders Cancer
- Cerebrovascular conditions (e.g. stroke, transient ischaemic attack (TIA))
- Dementia/Alzheimers disease
- Diabetes
- Heart conditions
- Human Immunodefi ciency Virus (HIV), Acquired Immune Defi ciency Syndrome (AIDS) or any derivative of either
- Hypertension
- Kidney conditions
- Liver conditions
- Organ transplant
- Peripheral vascular disease
- Reduced immunity (e.g. as a result of medical treatment or a medical condition)
- Respiratory or lung conditions
- Terminal conditions
- Conditions for which you:

- are under investigation or on a treatment waiting list
- have changed your medication in the last 60 days
- have been treated by a medical practitioner in the last 90 days

Family History (Parents, Siblings, Children)

Bleeding Disorder	Yes	No	Problems with anesthesia	Yes	No
Diabetes	Yes	No	Asthma	Yes	No
High Blood Pressure	Yes	No	Breast Cancer	Yes	No
Heart Disease	Yes	No	Other Cancer	Yes	No
Arthritis	Yes	No	Stroke	Yes	No

Social History:

Marital Status: Single Married Divorced Widowed

Do you smoke or use any tobacco products? Yes No How much per day? ___________________________

Do you consume alcohol? Yes No How many per week? ____

Current Medications / Anticoagulants: Please list all prescriptions and over the counter medicines you are taking: ☐ None

Medication	Dose	Medication	Dose

Medication Allergies: *Yes* No If yes, to what? ____

Other Allergies: *Yes* No If yes, to what? ____

Labs: Have you had any labs for this problem? ____

Studies: Have you had any radiographic studies for this problem? ______________________________

Are there any special needs for this visit? *Yes* *No* If yes, please explain: ______________

____

Miscellaneous (optional):

Where did you grow up: ______________________________

Occupation:_______________________

If you could do anything for a living, what would you do: ___________________________________

Name of spouse/significant other:________________________, Occupation: ______________________

Favorite Restaurant: ______________________________, Location if not Austin: ________________

Favorite Meal/Food:___________________________

Favorite wine: _____________________ (red or white), Cocktail: _____________________________

Favorite Jewelry Designer: ___________________, Clothes Designer: ______________________

Favorite Perfume/Cologne: ____________________, Make of watch: _______________________

Favorite city/resort to visit or vacation:__________________________

Favorite Exercise/Activity/Hobby:____

Cosmetic New Patient Information Form (Continued)

(Face/Nose Procedure Patients Only):

Tell us about what would like to change about your face/Nose__________________________________

____

Do you have dry eye syndrome? Yes No

Do you have any facial paralysis or numbness? ____

Any problems breathing through your nose? ____

Any history of facial or nasal fractures? ____

Have you had any cosmetic facial injections? ____

Are you considering or have you had cosmetic dentistry? ______________________________________

(Breast Procedure Patients Only): Current Bra Cup Size _____ Desired Bra Cup Size _____

Tell us what you would like to have different with your breasts ______________________________

____

Is there a chance you might be pregnant? Yes No

Have you ever been pregnant? Yes No If yes, how many times? ___ how many children? ___

Did you breast feed? Yes No

Date of last mammogram _________ Normal Abnormal Please specify abnormality _________

Breast Biopsy? Yes No If yes, specify date ____________ Right Left Both

Breast Cancer Treatment? Yes No If yes, date and type of treatment ______________________

Breast Surgeon name & phone # ____

Oncologist name & phone # ____

(Abdominal Procedure Patients Only): Dress Size ___ Pant Size ___ Current Wt ___ Desired Wt __

Tell us about what you would like to change about your abdomen _______________________________

____

Have you ever had any abdominal surgery? ____

(Extremity / Body Contouring Patients Only):

Please circle any areas below that you would like body contouring.

Back Arms Hips Thighs Calves Knees

Review of Systems:

Do you have any of the following medical problems? Please **check the box and circle condition**

	YES	NO	Comments
General (weight gain, weight loss, fatigue, insomnia, fever)	☐	☐	
Vision (glasses, contact lenses, cataracts, glaucoma, dry eyes)	☐	☐	
Ear / Nose / Throat (sinus problems, hearing loss, ringing in ears)	☐	☐	
Heart (irregular heartbeat, murmur, high blood pressure, heart disease)	☐	☐	
Pulmonary(short of breath, lung disease, persistent cough, sleep apnea)	☐	☐	
Stomach and Intestinal (decreased appetite, constipation, heartburn, nausea, vomiting, diarrhea, hepatitis A, B, C)	☐	☐	
Muscle and Skeletal (arthritis, fractures, sprains, spine problems)	☐	☐	
Genital Organs and Urinary System (kidney stones, bladder or kidney infections, kidney disease, prostate problems)	☐	☐	
Skin (swelling, blisters, dermatitis, eczema, acne, keloids)	☐	☐	
Neurological (problems with swallowing, seizures, tingling sensation, numbness, severe headaches)	☐	☐	
Psychiatric (anxiety, depression, bulimia, anorexia, other)	☐	☐	
Endocrine (increased thirst, diabetes, thyroid disease)	☐	☐	
Hematology (bleeding problems or clots, anemia)	☐	☐	
Immune (swollen or enlarged lymph nodes, cancer)	☐	☐	

Please list any other medical problems for which you are being treated _______________________

____

Patient Signature: ____ Date: _________________

Name: ____ Date:__________________________________

Physician Signature: ____ Date: ____________________