CAPELLA PLASTIC SURGERY -- PATIENT INFORMATION

Date_____

Salutation_____ **First Name**_____ **Middle Initial**____ **Last Name**_____

Address_____ **Home # ( )**_____

City_____**State**_____**Zip**_____ **Cell # ( )**_____

E-Mail_____ **Work # ( )**_____

Confirm E-Mail_____ **Fax # ( )**_____

Marital Status_____ **Name of Spouse**_____

Your Birth Date_____**Age**_____**Sex**_____**SS#**_____

Occupation_____

Company_____

Address_____

City_____**State**_____**Zip**_____

Emergency Contact

Name_____
Address_____
City_____ **St** ____ **Zip** _____
Telephone #_____
Relationship to you_____

How did you hear about us? (Please check all that apply):

Referred by a patient □ Patient's Name_____

Referred by physician □ Physician's Name_____

Address: _____

City _____ Phone# ( ) _____

State _____Zip Code_____ Fax # ( ) _____

Google.com □ Obesity.com □ Ienhance.com □

Other: _____

Primary Care Physician:

Name: _____ Phone # ( ) _____

Address: _____ Fax # ( ) _____

City: _____

State: _____Zip code_____

Primary reason for visit:

_____

_____

Other procedures that I am interested in (Please check all that apply)

Liposuction •	Face Lift •	Breast Augmentation •	Scar Revisions •
Tummy Tuck •	Neck Lift •	Breast Reduction •	Botox Injections •
Body Lift •	Eyelid Surgery •	Breast Lift •	Restylane Injections •
Arm Lift •	Brow Lift •	Male Breast Surgery •	Radiesse Injections •
Buttock Lift •	Forehead Lift •	Chemical Peels •	
Thigh Lift •	Nose Surgery •	Fat Grafting •	

Past Surgical History

Please list all operations you have had below, including plastic and cosmetic procedures

Date	Type of surgery
___/___/___	_____
___/___/___	_____
___/___/___	_____
___/___/___	_____
___/___/___	_____
___/___/___	_____

Past Medical History

	Now	In the Past
Chicken Pox	_____	_____
Measles	_____	_____
German Measles	_____	_____
Mumps	_____	_____
Rheumatic Fever	_____	_____
Scarlet Fever	_____	_____
Polio	_____	_____
Arthritis	_____	_____
Asthma	_____	_____
Emphysema	_____	_____
Respiratory Problems	_____	_____
Tuberculosis	_____	_____
Seizures	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
Kidney Disease	_____	_____
Hypertension	_____	_____
Hepatitis	_____	_____
Heart Attack	_____	_____
Heart Disease	_____	_____
Angina	_____	_____
Stroke	_____	_____
Bleeding Tendency	YES	NO
HIV or AIDS	YES	NO
DVT (blood clot in legs)	YES	NO
Pulmonary Embolism	YES	NO
Herpes	YES	NO
Zoster	YES	NO

Breast History

Date of last mammogram ___/___/___
History of breast cancer? YES NO
Family member:
Mother ____ Sister ____ Aunt ____ Grandmother ____

Skin Cancer History

Melanoma	YES	NO
Basal Cell	YES	NO
Squamous Cell	YES	NO

Habits & Psychiatric History

Do you drink alcohol? YES NO How much? _____

Do you smoke? YES NO How much? _____
Were you ever a smoker? YES NO
When did you quit? _____

Do you use any recreational drugs? YES NO
Marijuana ____ Cocaine ____ Heroin ____ Other _____

Have you suffered from mental illness? YES NO

Have you ever been hospitalized for mental illness? YES NO

Menstrual History

Number of Pregnancies ____ Number of Children ____
Birth Control Pills? _____ Other contraception? ____

Family History

Have any of your close relatives had any of these diseases? (Mother, Father, Sister, Brother, Daughter, Son)

Anemia	_____
Bleeding Tendency	_____
Diabetes	_____
Heart Attack	_____
Heart Disease	_____
Hypertension	_____
Stroke	_____
Cancer	_____
Mental Disorder	_____

Weight History

Maximum weight _____ Date ___/___/___ BMI _____

Current Weight _____ Height: Feet ____ Inches _____

Medications

Please list all medications you take, including prescriptions, birth control and over-the-counter medications (e.g. Tylenol, Aspirin, Motrin, etc)

Medication _____ Dose _____ How often _____

Medication _____ Dose _____ How often _____

Medication _____ Dose _____ How often _____

Medication _____ Dose _____ How often _____

Medication _____ Dose _____ How often _____

Medication _____ Dose _____ How often _____

Medication _____ Dose _____ How often _____

Medication _____ Dose _____ How often _____

Medication _____ Dose _____ How often _____

Medication _____ Dose _____ How often _____

Allergies

Please list all medications and foods that you are allergic to:

Medication _____ Reaction _____

Medication _____ Reaction _____

Medication _____ Reaction _____

Medication _____ Reaction _____

Do you have a latex allergy? YES NO
Can you receive blood/products? YES NO

By my signature below, I attest that the medical information I have given is true and accurate.

_____ Date _____
Signature of Patient/Guardian