Sunset Cosmetic Surgery

PERSONAL INFORMATION Today's Date:

First Name:_ _____ Last Name: _____

Reason for Consultation: _____

Date of Birth: _____/____/_____ Age: _____ Sex: Female Divorced

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Employer: _____ Work Phone: (____) _____

Occupation: _____ Fax: (____) _____

Email: _____

PAST MEDICAL HISTORY

Prior Surgeries or Procedures: _____

_____

_ Are you currently being treated for any medical condition(s), or have you been in the past? No

Please list: _____

Ever Seen a Psychiatrist or Psychologist? _____ When? _____

Family History of Illnesses: _____

Current Medications: _____

Medication Allergies: _____ Easy Bruising or Bleeding: No

Pregnant: No Breast Feeding: No

Intials _____

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PATIENT HEALTH QUESTIONNAIRE

Height: _____ Weight: _____ Recent weight gain or loss: _____

Recent Chest X-Ray: No Comments: _____
Recent EKG: No Comments: _____
Recent Mammogram: No Comments: _____

Smoking History: no If yes, please give daily amount: _____

Alcohol Intake: no If yes, please give daily amount: _____

Have you ever had a history of the following?

Heart attack, stroke, rheumatic fever……. Yes
High/low blood pressure…… Yes
History of chest pain…….. Yes
Do your ankles swell……..……. Yes
Do you get short of breath easily……. Yes
Asthma……..…. Yes
Hives, rashes or skin disorders……..…. Yes
Fainting spells or seizes…… Yes
Diabetes …… Yes
Hepatitis, jaundice, cirrhosis…… Yes
Stomach ulcers or heart burn…… Yes
Arthritis…… Yes
Kidney problems…… Yes
Tuberculosis or persistent cough……. Yes
Coughing up blood…… Yes
Venereal disease…… Yes
Emotional disorders……..…. Yes
Excessive bleeding with prior surgery..…… Yes
Blood disorders or anemia ……..…. Yes
Tumors of the mouth, nose or throat……. Yes
Are you prone to or have ever had cold sores
Are you prone to or have ever had herpes or viral breakouts…..… Yes

If yes to any of the above, please elaborate:

_____
_____
_____
_____

Are you taking any of the following?

Antibiotics……..…… Yes
Blood thinners……..…… Yes
Diet pills……...…….. Yes
Steroids, NSAIDS…… Yes
Aspirin, Motrin……..... Yes
Insulin……..…….. Yes
Heart medicine……..…… Yes
Herbal supplements……..…… Yes
Birth control pills……..…. Yes
Hormone supplements……..…….. Yes

If yes to any of above, please list name and dose of medication(s):

_____
_____
_____

Is there any reason you would not accept a transfusion in an emergency situation? Yes

Allergies and Sensitivities:

Local Anesthetics…… Yes
General Anesthetics…… Yes
Antibiotics (Penicillin)…… Yes
Barbiturates, Sedatives…… Yes
Morphine or Codeine…… Yes
Adhesive Tapes..…….. Yes
Latex…… Yes

Signature of Patient, Parent or Guardian:XX _____

EMERGENCY CONTACT INFORMATION

In case of an emergency, please notify: _____

Relationship: _____
Cell Phone: _____
Home Phone: _____

I, the undersigned, represent that all of the information on this form is true and complete to the best of my knowledge and that I accept full financial responsibility for professional, medical and surgical services rendered.

Patient / Insured Signature: _____

Print Name: _____

REFERRAL INFORMATION

How did you <u>first</u> hear about us? Please check one.

☐ One of our patients: _____

☐ Another Doctor: _____

☐ Magazine Advertising or Article: _____

☐ Online Search Engine(s) (Google, Yahoo, MSN, Bing, etc. – please list) _____

☐ Online site(s): ○ 1-800-MYSURGEON ○ Implant Info by Nicole ○ Other (please list): _____

☐ Online Yellow Pages: ○ Yahoo! Yellow Pages ○ Superpages.com ○ Yellowpages.com ○ Not Sure

☐ Yellow Pages/Phone Book

☐ Television: _____

☐ Other (please explain): _____

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

I acknowledge the above notice and understand that the physician is licensed and regulated by the Board.

Patient / Insured Signature: X X_____ Date: _____

Overall health and body concerns:

- ☐ Always tired and too little energy
- ☐ Wish to lose weight
- ☐ Wish my mood was better
- ☐ Don't feel as sexy or sexual as I want
- ☐ Improve mental clarity and sharpness
- ☐ Wish I had better sleep

Facial Aging & Expressions

When looking at my face in the mirror, I believe I look:

- ☐ Younger than my true age.
- ☐ About right for my age.
- ☐ Older than my true age.

When looking in the mirror, I am:

- ☐ Not concerned about wrinkles.
- ☐ Somewhat concerned about the appearance of my wrinkles.
- ☐ Very concerned about the appearance of my wrinkles.

- ☐ Desire more youthful skin
- ☐ Tired eyes
- ☐ Sagging skin, jowls, neck
- ☐ Wrinkles
- ☐ Face gaunt or hollow
- ☐ Chubby or "chipmunk" cheeks
- ☐ Facial expression [too old, sad, angry, tired]
- ☐ Heavy brow
- ☐ Acne
- ☐ Wish to enhance eyelashes or brows
- ☐ Hyper pigmentation or Melasma
- ☐ Sun damage
- ☐ Age spots
- ☐ Facial veins
- ☐ Weak chin/jaw
- ☐ Improve appearance of Nose
- ☐ Ears too prominent
- ☐ Lips not as attractive as before
- ☐ Other_____

Breast Size/Shape

- ☐ Too small
- ☐ Too big
- ☐ Uneven
- ☐ Unattractive shape
- ☐ Too saggy
- ☐ Nipple size
- ☐ Not enough cleavage
- ☐ Other_____

Body Size/Shape/Contours

- ☐ Abdomen – Stomach – Waistline
- ☐ "Love handles"
- ☐ Thighs – Legs – Calves
- ☐ Arms
- ☐ Buttocks
- ☐ Other_____

Other Services

- ☐ Leg veins or spider veins
- ☐ Eliminating underarm sweating
- ☐ Eliminating sweaty palms