PELED SURGERY

COSMETIC HISTORY FORM

IF THIS IS YOUR FIRST VISIT WITH US, PLEASE TAKE THE TIME TO FILL THIS FORM OUT COMPLETELY.

Patient Name: _____ Age: _____ Date of Birth: _____ Weight: _____ Height:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail address _____ Emergency Contact _____

Emergency Contact Info_____

Emergency Contact relationship to you_____

Social Security#: _____ Preferred Contact_____

How did you hear about us? _____

Reason for today's visit: _____

Are there specific health issues, procedures or products of interest to you? (Please check all that apply)

- ❑ Nose re-shaping (rhinoplasty)
- ❑ Tummy tuck (abdominoplasty)
- ❑ Liposuction
- ❑ Facelift
- ❑ Prominent ears (otoplasty)
- ❑ Arm lift (brachioplasty)
- ❑ Male breast reduction
- ❑ Eyebrow lift
- ❑ Breast augmentation
- ❑ Eye rejuvenation (blepharoplasty)
- ❑ Skin Care Advice
- ❑ Sunscreen Advice
- ❑ Skin Rejuvenation
- ❑ Birthmarks/Moles/Scarring
- ❑ Latisse™ eyelash growth product
- ❑ BOTOX Cosmetic™ or Dysport™ (i.e. Botulinum Toxin Type A)
- ❑ Injectable fillers (e.g. Juvederm™, Radiesse™, Restylane™, Perlane™)
- ❑ Other, please specify_____

_____

PAYMENT OPTIONS:

- MasterCard & Visa are accepted
- Personal checks are accepted at least 14 days prior to surgery
- Payment financing is available via Care Credit

PELED SURGERY

Do **you currently** have any of the following conditions?

	YES	NO		YES	NO		YES	NO
EYES			ENDOCRINE			GENITOURINARY		
Cataract(s)	❑	❑	Insulin dependent diabetes	❑	❑	Pain w/ urination	❑	❑
Visual disturbance(s)	❑	❑	Diabetes controlled with pills	❑	❑	Kidney/bladder infection	❑	❑
Glaucoma	❑	❑	Diabetes controlled with diet	❑	❑	Kidney stone(s)	❑	❑
Retinal problems	❑	❑	Thyroid disease	❑	❑	Hysterectomy	❑	❑
EAR, NOSE, THROAT			Parathyroid disease	❑	❑	Blood in urine	❑	❑
Sore throat	❑	❑	Psychiatric disorders	❑	❑	Uterine fibroids	❑	❑
Chronic sinus drainage	❑	❑	CARDIAC			MUSCOLOSKELETAL		
Nasal breathing issues	❑	❑	Heart disease	❑	❑	Joint Pain/Swelling	❑	❑
RESPIRATORY			Heart attack	❑	❑	Herniated disk	❑	❑
Use oxygen at home	❑	❑	Angina	❑	❑	Arthritis	❑	❑
Emphysema	❑	❑	Heart failure	❑	❑	Back pain/injury	❑	❑
Asthma	❑	❑	Hypertension	❑	❑	NEUROLOGIC		
GASTROINTESTINAL			Pacemaker	❑	❑	Stroke	❑	❑
Chronic nausea	❑	❑	Cardiac bypass	❑	❑	TIA (AKA "minor stroke")	❑	❑
Chronic vomiting	❑	❑	Cardiac catheterization	❑	❑	Migraines	❑	❑
Abdominal pain	❑	❑	Angioplasty	❑	❑	Neuropathy	❑	❑
Diarrhea	❑	❑	High cholesterol	❑	❑	SKIN		
Black/bloody stools	❑	❑	HEME/LYMPH			Moles	❑	❑
Hepatitis	❑	❑	Recent lymph node swelling	❑	❑	Poor scarring	❑	❑
Gall stones	❑	❑	Chronic lymph node swelling	❑	❑			
Hernia(s)	❑	❑						
Spleen problems	❑	❑						

PAST MEDICAL HISTORY:

Have **you ever** had any of the following?

Anemia	❑ Yes	❑ No	Heart murmur	❑ Yes	❑ No	Mitral valve prolapse	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Rheumatic fever	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Skin cancer	❑ Yes	❑ No
Bleeding problem	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Blood transfusion	❑ Yes	❑ No	High blood pressure	❑ Yes	❑ No	Thyroid disease	❑ Yes	❑ No
Cancer (other)	❑ Yes	❑ No	HIV/AIDS	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Heart disease	❑ Yes	❑ No	Kidney disease	❑ Yes	❑ No			

If yes to any of the above, please describe the condition:_____

_____

_____

PAST SURGICAL HISTORY (including cosmetic surgery):

Please list any previous surgery with approximate dates:

Procedure	Date	Procedure	Date

FAMILY HISTORY:

Do you have **family members** with any of the following conditions:

Breast Cancer	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No
Other Cancer	❑ Yes	❑ No	Stroke	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No
MIGRAINES	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Depression	❑ Yes	❑ No

If yes to any of the above, please describe the condition and identify your relation to the family member:_____

_____

_____

_____

MEDICATIONS:

Please list any prescription, non-prescription, and herbal medications you are taking along with doses. If you have a long list, please bring it to us.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

DRUG ALLERGIES:_____

SOCIAL HISTORY:

Marital Status: _____ Spouse's name _____

Are you currently employed? yes ___ no ___ If so, what do you do?_____

Do you smoke? yes ___ no ___ If so, how many packs per day? _____

If you smoked in the past, when did you quit? _____

On average, how many alcoholic drinks do you have per week? _____

Insurance Information:

Primary Insurance:_____Phone #: _____

Address:_____Policy #:_____ Group #: _____

Policy Holder:_____ Social Security #: _____ DOB:_____

Secondary Insurance: _____Phone #: _____

Address:_____Policy #:_____ Group #: _____

Policy Holder:_____ Social Security #: _____ DOB:_____

Primary Care Physician: _____ Phone: _____ Fax_____

Address_____City/State_____Zip_____