

# BUCKHEAD FACIAL PLASTIC SURGERY

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## CONSULTATION AND MEDICAL QUESTIONNAIRE

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

(Circle one) Mrs. Miss Ms. Mr. Dr. Social Security #: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name you prefer to be called \_\_\_\_\_ Marital Status  S  M  D  W Children's ages: \_\_\_\_\_

Occupation \_\_\_\_\_ Email address: \_\_\_\_\_

May we contact you by email? Yes No

Home telephone: (\_\_\_\_\_) \_\_\_\_\_ Business telephone: (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ / Pager (\_\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Referred By: (check the appropriate response)

- Doctor (name: \_\_\_\_\_)  Attended a lecture  Internet  
 Friend (name: \_\_\_\_\_)  Telephone Yellow Pages  Magazine  
 Family (name: \_\_\_\_\_)  Other \_\_\_\_\_

### Check the areas you would like to discuss:

- Nose  Chin Implant  Brow/Forehead Lift  Protruding Ears  Botox  
 Face/Neck Lift  Liposuction  Chemical Peel/Laser  Moles, Cysts, etc.  Filler  
 Eyelids  Scar Revision  Dermabrasion  Other \_\_\_\_\_

When did you begin to consider surgical correction? \_\_\_\_\_

What specifically would you like to have corrected? \_\_\_\_\_

Have you consulted another doctor about this?  No  Yes (Whom?) \_\_\_\_\_

Have you discussed this surgery with your family?  No  Yes Are they agreeable?  No  Yes

Are they willing to help you during recovery?  No  Yes

Has anyone in your family or a close friend had cosmetic or reconstructive surgery?  No  Yes

What was done and by whom? \_\_\_\_\_

### LIST ALL OPERATIONS YOU HAVE HAD, INCLUDING COSMETIC SURGERY?

Operation	Year	Doctor	City
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Were there any complications?  No  Yes \_\_\_\_\_

Did you have a normal recovery?  No  Yes (explain) \_\_\_\_\_

Were you satisfied with the results?  No  Yes (explain) \_\_\_\_\_

Have you had an injury, to the face, nose, neck, or eyes? No Yes  
When? \_\_\_\_\_ If so, describe: \_\_\_\_\_

Have you been advised to have a surgical procedure that has not yet been performed? No Yes  
Is having surgery your idea or someone else's idea? \_\_\_\_\_

Have you read articles in newspapers, magazines, or books about cosmetic surgery? No Yes  
(list publications) \_\_\_\_\_

Do you understand that the goal of any cosmetic surgery is **improvement** in appearance, not perfection? No Yes

**CHECK BELOW THE REASONS WHY YOU DESIRE SURGERY:**

- |  |  |
|--|--|
| <input type="checkbox"/> To improve my appearance          | <input type="checkbox"/> To eliminate self-consciousness about my appearance |
| <input type="checkbox"/> To improve function               | <input type="checkbox"/> Because people tease me or make derogatory remarks  |
| <input type="checkbox"/> To give perfection to my looks    | <input type="checkbox"/> To make me look masculine or feminine               |
| <input type="checkbox"/> To help me look better for my age | <input type="checkbox"/> My looks prevent achievement of certain goals       |
| <input type="checkbox"/> To give me a psychological uplift | <input type="checkbox"/> To improve my relations with the opposite sex       |
| <input type="checkbox"/> To help obtain or keep a job      | <input type="checkbox"/> To cause other people to react better to me         |
| <input type="checkbox"/> To please or impress others       | <input type="checkbox"/> Because of a family resemblance I dislike           |
| <input type="checkbox"/> To achieve certain career goals   | <input type="checkbox"/> Have an inferiority complex about my appearance     |
| <input type="checkbox"/> Because I look tired              | <input type="checkbox"/> My looks prevent achievement of certain goals       |
| <input type="checkbox"/> To help solve personal problems   |  |

**MEDICAL HISTORY:**

Do you take any **PRESCRIPTION** or **OVER THE COUNTER** medication regularly? No Yes  
(Please list) \_\_\_\_\_

Do you take any prescription or over-the-counter medication occasionally? No Yes  
(Please list) \_\_\_\_\_

Do you take vitamins, herbs or minerals? No Yes (Please list) \_\_\_\_\_

**Are you allergic to any medication?** No Yes (please list)

Medication	What happened when you took this medication?
_____	_____
_____	_____
_____	_____

Are you allergic to any of the following? (circle) Eggs/Soap/Adhesive tape/Iodine/Ointments/Suture Material  
Have you received local anesthesia (Novocaine/ Lidocaine) by a dentist or doctor? No Yes  
Have you had a "reaction" to any anesthetic? No Yes Explain: \_\_\_\_\_

**Indicate if any member of your family has had trouble with:**

	RELATIVE	RELATIONSHIP
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Heart Trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
High blood pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Excessive scarring	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Cancer, including skin cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

**Please answer the following questions to the best of your knowledge:**

- No  Yes **Have you ever had: (Circle)** asthma/bronchitis/pneumonia/emphysema/recent cold/chronic cough/other similar condition: \_\_\_\_\_
- No  Yes Do you smoke? If yes, number of packs per day \_\_\_\_\_ for how long \_\_\_\_\_
- No  Yes Do you have any known problems with sleep apnea?
- No  Yes **Have you ever had: (Circle)** sinusitis/hay fever/respiratory allergies  
Are you seeing an ENT physician for this condition?  No  Yes
- No  Yes **Have you ever had: (Circle)** high blood pressure/chest pain/heart attack/mitral valve prolapse/abnormal EKG/irregular heart beat/other heart conditions:  
\_\_\_\_\_
- No  Yes **Have you ever had: (Circle)** ulcers/hiatal hernia/gallbladder problems/jaundice/  
bowel problems/frequent nausea/frequent vomiting/hepatitis/ other stomach  
problems \_\_\_\_\_
- No  Yes Do you drink any alcoholic beverages? Number of drinks per day \_\_\_\_\_
- No  Yes Are you a vegetarian?
- No  Yes **Have you ever had: (Circle)** seizures/chronic neck or back pain/stroke/muscle  
weakness/migraine headaches/paralysis/other similar problems \_\_\_\_\_
- No  Yes **Do you have a blood sugar disorder: (Circle)** diabetes/hypoglycemia/hyperglycemia  
How is it controlled? (Circle) diet controlled/oral medication/injectable medication/  
other \_\_\_\_\_
- No  Yes **Have you ever had: (Circle)** goiter/hypothyroid/hyperthyroid/  
Other: \_\_\_\_\_
- No  Yes **Have you ever had: (Circle)** frequent urinary tract infections/urinary retention/  
stones/prostate problems/other: \_\_\_\_\_
- No  Yes **Do you or have you had Cancer:** Type \_\_\_\_\_  
(Circle treatment) chemotherapy/radiation/surgery/other: \_\_\_\_\_
- No  Yes **Do you have Bleeding or Blood Abnormalities: (Circle)** blood clotting  
abnormalities/bruise easily/blood transfusion/anemia/  
other: \_\_\_\_\_
- No  Yes Have you ever been tested for HIV?  
**If YES, was the result of this test: (Circle One)** positive or negative
- No  Yes **Have you ever had: (Circle)** vitiligo/skin pigmentation disorder/herpes/shingles/  
keloid scarring/cold sores/fever blisters/other skin conditions: \_\_\_\_\_
- No  Yes Are you taking or have you taken Accutane? When? \_\_\_\_\_
- No  Yes Are you using Retin-A?
- No  Yes Have you used or are you using prescription skin preparations?  
Please list \_\_\_\_\_

No  Yes **Have you ever seen a Psychologist/Therapist for: (Circle all that apply)**  
Depression/Schizophrenia/Nervous Breakdown/Drug Abuse  
Rehabilitation/Alcohol Rehabilitation/Anxiousness/Treatment with  
Psychiatric professional/Other \_\_\_\_\_

No  Yes Do you often feel unhappy or depressed?

No  Yes Does criticism always upset you?

No  Yes Are you considered a nervous person?

No  Yes Are you easily upset or irritated?

No  Yes Do you usually sleep well?

No  Yes Is your appetite OK?

No  Yes Do you hold a grudge when someone angers you?

No  Yes Do you have any medical problems that have not been covered?

Explain: \_\_\_\_\_

**Women:**

No  Yes Have you had a hysterectomy?

No  Yes Are your periods often irregular?

No  Yes Have you had "female" or GYN problems? Explain \_\_\_\_\_

No  Yes Is there any possibility that you are pregnant?

When was your last menstrual period? \_\_\_\_\_

**Men:**

No  Yes Have you had prostate problems?

Who is your family Doctor? \_\_\_\_\_

City \_\_\_\_\_ Phone number (\_\_\_\_\_) \_\_\_\_\_

When was your last physical examination? \_\_\_\_\_

May we contact him/her in regard to your medical history?  No  Yes

**Please answer the following:**

No  Yes Do you understand that surgical fees are to be paid in full prior to surgery regardless of insurance coverage? (Should your surgery include a functional or reconstructive component, your insurance company may rebate some of the costs. We do not know the amount of coverage you will receive. This is determined by your insurance company.)

No  Yes Do you accept the fact that there are risks involved in every medical and surgical treatment?

No  Yes Are you aware that the possibility exists that the result of the operation might not fully meet your expectations?

No  Yes Do you realize that every operation is followed by a period of healing of one year or more before the tissues return to normal and the final result is apparent?

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_