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: _____)
- ☐ Friend (name: _____)
- ☐ Family (name: _____)
- ☐ Attended a lecture
- ☐ Telephone Yellow Pages
- ☐ Other_____
- ☐ Internet
- ☐ Magazine

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:

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

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	□No □Yes	_____
Heart Trouble	□No □Yes	_____
High blood pressure	□No □Yes	_____
Excessive scarring	□No □Yes	_____
Cancer, including skin cancer	□No □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** _____