

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 _____

State _____ Zip Code _____

Google.com <input type="checkbox"/>	Obesity.com <input type="checkbox"/>	lenhance.com <input type="checkbox"/>
Other: _____		

Phone# () _____

Fax # () _____

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.

 Signature of Patient/Guardian Date _____