



NORTHWEST CENTER  
FOR AESTHETIC PLASTIC SURGERY

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

Dear Patient,

We welcome the opportunity to participate in your medical care. To ensure maximum safety and efficiency and to assist us in providing you with the best care possible, we ask that you provide accurate and detailed answers to these questions. Thank you for your assistance and we look forward to caring for you.

On what part of the body are you considering having surgery?

\_\_\_\_\_

What specific features are you hoping to improve?

\_\_\_\_\_

What are your expectations regarding your result?

\_\_\_\_\_  
\_\_\_\_\_

What prompted your interest in this and when did you begin to think about the possibility of having plastic surgery?

\_\_\_\_\_  
\_\_\_\_\_

Have you ever had plastic surgery or has any family member or friend of yours ever had plastic surgery? If you had plastic surgery, what procedures were performed? When were they performed and what was the result?

\_\_\_\_\_  
\_\_\_\_\_

Have you spoken with your spouse, significant other, family, friends, or primary care physician about your desire for surgery? If so, what was their reaction?

\_\_\_\_\_  
\_\_\_\_\_

Have you experienced any recent significant changes in your life?

\_\_\_\_\_  
\_\_\_\_\_

Have you ever been under the care of a Psychiatrist or Psychologist?

\_\_\_\_\_  
\_\_\_\_\_

Is there anything else you feel we should know to help us best care for you?

\_\_\_\_\_  
\_\_\_\_\_

Patient name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: ( ) F ( ) M Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs.

Please List **ALL** allergies (please include food, medication, and contact allergies): \_\_\_\_\_

Please List **ALL** Current Medications (please include vitamins, minerals, and herbs); Have you ever used **Accutane**, if yes, last day of use: \_\_\_\_\_

Please List **ALL** Previous Operations, Including Dates (including cosmetic procedures): \_\_\_\_\_

Please List any personal or family history of breast cancer: \_\_\_\_\_

**\*If you answer: yes to any of the following questions(except question 12), please explain your answers in the space provided at the bottom of page two.\***

1. Have you ever had an anesthetic? ( ) No ( ) Yes
2. Have you ever had a problem with anesthesia? ( ) No ( ) Yes
3. Has any one related to you ever had a problem with anesthesia? ( ) No ( ) Yes
4. Do you consume alcohol?  
If yes, how much, and how often? \_\_\_\_\_ ( ) No ( ) Yes
5. Do you smoke or use Nicotine in any form (or have you ever had a history of use)?  
If yes, how much, and how many years? \_\_\_\_\_ ( ) No ( ) Yes
6. Does anyone you live with smoke? ( ) No ( ) Yes
7. Do you have a cough? ( ) No ( ) Yes
8. Do you bring up anything when you cough? ( ) No ( ) Yes
9. Do you have asthma? ( ) No ( ) Yes
10. Have you ever had an abnormal chest X-ray? ( ) No ( ) Yes
11. Do you have difficulties breathing? ( ) No ( ) Yes
12. Can you walk up two flights of stairs without getting short of breath? ( ) No ( ) Yes
13. Are you short of breath at night or do you have sleep apnea? ( ) No ( ) Yes
14. Do you have a heart murmur? ( ) No ( ) Yes
15. Have you ever had a heart attack? ( ) No ( ) Yes
16. Have you ever had angina or pain in the chest related to your heart? ( ) No ( ) Yes
17. Have you ever had an abnormal EKG? ( ) No ( ) Yes
18. Have you ever had high blood pressure? ( ) No ( ) Yes
19. Do you have any bleeding tendencies? ( ) No ( ) Yes

- 20. Have you ever had any abnormal blood clots?  No  Yes
- 21. Have you ever been anemic?  No  Yes
- 22. Have you ever been anorexic?  No  Yes
- 23. Have you ever had kidney disease?  No  Yes
- 24. Have you ever been jaundiced?  No  Yes
- 25. Have you ever had hepatitis?  No  Yes
- 26. Do you have a hiatus hernia or get heartburn?  No  Yes
- 27. Have you ever been bulimic?  No  Yes
- 28. Have you ever had a stroke?  No  Yes
- 29. Do you have an arm or leg that becomes weak or numb?  No  Yes
- 30. Have you ever had seizures, episodes of unconsciousness, or fainting?  No  Yes
- 31. Do you have frequent headaches?  No  Yes
- 32. Have you ever had an eye problem or problems with your vision?  No  Yes
- 33. Do you have diabetes?  No  Yes
- 34. Do you have arthritis?  No  Yes
- 35. Do you have any physical disabilities?  No  Yes
- 36. Have you used aspirin in the last two weeks?  No  Yes
- 37. Do you have any chipped or loose teeth?  No  Yes
- 38. Do you have caps, bridgework, dentures, or braces?  No  Yes
- 39. Is there anything else you feel you should share with us?  No  Yes

**FEMALE PATIENT(S):**

- 40. Could you be pregnant?  No  Yes
- 41. Date of last period? \_\_\_\_\_ Days in cycle? \_\_\_\_\_ Length? \_\_\_\_\_ Contraceptive method? \_\_\_\_\_
- 42. Number of previous pregnancies? \_\_\_\_\_ Live births? \_\_\_\_\_
- 43. Any further comments? \_\_\_\_\_.

**Please explain any questions you may have answered yes, in the space provides below (please include the number of the question to which you are responding, Thank you.).**

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Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_