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? 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?

_____

_____

Anything else you feel we should know to help us best care for you?
(Please take time to think about this question so we can better serve you)

_____

_____

Patient Name: _____ Date of Birth: ____/____/____

Date of Birth: ___/___/___ *Age:* _____ *Sex: ( ) F ( ) M Height:* _____ *Weight:* _____*lbs.*

*Please List **ALL** allergies (please include food, medication, and contact allergies, ie: tape, adhesive, latex):*

_____

*Please List **ALL** Current Medications (please include vitamins, minerals, & herbs):* Have you ever used **Accutane?** last day of use:

_____

_____

*Please List **ALL** Previous Operations* (**Including Cosmetic procedures and dates**):

_____

_____

Please List any personal or family history of breast cancer:

_____

ANY 'yes' to questions (except question 13), please explain your answers in the space provided at the end of questionnaire.

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 or any family member have a history of Malignant Hyperthermia (M.H.) ( ) No ( ) Yes
   (Please circle any of the following if you or any family member has experienced: Unexpected death following general anesthesia or exercise, muscular or neuromuscular disorder, high temperature following exercise, personal history of muscle spasms, dark or chocolate colored urine, or unanticipated fever immediately following anesthesia or serious exercise)
5. Do you consume alcohol? ( ) No ( ) Yes
   If yes, how much, and how often? _____
6. Do you use Nicotine in <u>any form</u>(or have you ever had a history of use)? ( ) No ( ) Yes
   If yes, how much, and how many years? _____
6. Does anyone you live with smoke? ( ) No ( ) Yes
7. Do you smoke or use marijuana in any form? ( ) No ( ) Yes
8. Do you have a cough? ( ) No ( ) Yes
9. Do you bring up anything when you cough? ( ) No ( ) Yes
10. Do you have asthma? ( ) No ( ) Yes
11. Have you ever had an abnormal chest X-ray? ( ) No ( ) Yes

Patient Name: _____ Date of Birth: ____/____/____

12. Do you have difficulties breathing? ( ) No ( ) Yes

13. Can you walk up two flights of stairs without getting short of breath? ( ) No ( ) Yes

14. Are you short of breath at night or do you have sleep apnea? ( ) No ( ) Yes

15. Do you have a heart murmur? ( ) No ( ) Yes

16. Have you ever had a heart attack? ( ) No ( ) Yes

17. Have you ever had angina or pain in the chest related to your heart? ( ) No ( )Yes

18. Have you ever had an abnormal EKG? ( ) No ( ) Yes

19. Have you ever had high blood pressure? ( ) No ( ) Yes

20. Do you or any family members have any bleeding tendencies? ( ) No ( ) Yes

21. Have you or any family member ever had any abnormal blood clots? ( ) No ( ) Yes

22. Have you ever been anemic? ( ) No ( ) Yes

23. Have you ever been anorexic? ( ) No ( ) Yes

24. Have you ever had kidney disease? ( ) No ( ) Yes

25. Have you ever been jaundiced? ( ) No ( ) Yes

26. Have you ever had hepatitis, hepatitis C or HIV? ( ) No ( )Yes

27. Do you have a hiatus hernia or get heartburn? ( ) No ( ) Yes

28. Have you ever been bulemic? ( ) No ( ) Yes

29. Have you ever had a stroke? ( ) No ( ) Yes

30. Do you have an arm or leg that becomes weak or numb? ( ) No ( ) Yes

31. Have you ever had seizures, episodes of unconsciousness, or fainting? ( ) No ( ) Yes

32. Do you have frequent headaches? ( ) No ( ) yes

33. Have you ever had an eye problem or problems with your vision? ( ) No ( ) Yes

34. Do you have diabetes? ( ) No ( ) Yes

Patient Name: _____ Date of Birth: ____/____/____

35. Do you have arthritis? ( ) No ( ) Yes

36. Do you have any physical disabilities? ( ) No ( ) Yes

37. Have you used aspirin in the last two weeks? ( ) No ( ) Yes

38. Do you have any chipped or loose teeth? ( ) No ( ) Yes

39. Do you have caps, bridgework, dentures, or braces? ( ) No ( ) Yes

40. Do you have or have you ever had cold sores? ( ) No ( ) Yes

41. Is there anything else you feel you should share with us? ( ) No ( ) Yes

_____

_____

FEMALE PATIENT(S):

42. Could you be pregnant? ( ) No ( ) Yes

Date of last period? _____ Days in cycle? _____ Length? _____ Contraceptive method? _____

43. Number of previous pregnancies? _____ Live births? _____

44. 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.).

_____

_____

_____