

**GOLD COAST PLASTIC SURGERY
HEALTH AND MEDICAL HISTORY**

Patient Name _____ Today's Date _____
 Date of Birth _____ Age _____ Referral Source _____
 Primary Physician _____ Telephone _____

Procedures I would like to discuss with the doctor (Check all that apply):
Facial Rejuvenation: Face Lift Eyelid Correction Forehead/Brow Lift Neck Lift Mohs Closure
Nasal Surgery: Cosmetic Sinus/Septum Problems Corrective
Facial Implants: Chin Implant Cheek Implants
Ear Surgery: Reduce Prominence Reduce Earlobe Size Repair Torn Earlobe
Skin Rejuvenation: Laser Resurfacing Blue Peel Dermabrasion Mole/Cyst Removal Scar Revision
Injectables/Wrinkle Treatment: Botox Juvederm Silikon 1000
Other Procedure: _____

When did you begin to consider surgical correction? _____
 Why have you decided to have the procedure at this time? _____
 Have you consulted with any other doctors regarding this procedure?(When?) _____
 Have you discussed this procedure with your family? Yes No
 Are they agreeable with your decision? Yes No
 When was your last physical exam? _____ Performing Physician: _____
 May we have permission to consult with your physician if necessary? Yes No

Have you had any previous cosmetic surgery/procedures? Yes No
 If "Yes," What procedure? _____
 Procedure Date: _____ Performing Physician: _____
 If procedure was injury related, describe injury: _____
 Date of Injury: _____ Complication of injury: _____
 Date of Treatment: _____ Treatment received: _____

Please list and date any other surgeries, procedures, and/or hospitalizations:
 Head & Neck _____ Teeth/Gums _____
 Abdomen _____ Skin _____
 Reproductive System _____ Chest/Back/Arms/Legs _____
 Other _____
 Did you have a normal recovery? Yes No-- _____
 Did the results meet your expectations? Yes No-- _____

Please check if you or members of your family have had the following (indicate what/who):
 Heart Trouble _____ Diabetes _____ Delayed/Poor Healing _____
 High Blood Pressure _____ Chest/Lung Problems _____ Psychiatric Nerve Problems _____
 Thyroid Disease _____ HIV/AIDS _____ Stomach Trouble/Ulcers _____
 Excessive Bruising _____ Anemia _____ Severe Headaches/Dizziness _____
 Excessive Bleeding _____ Paralysis/Numbness _____ Kidney/Bladder Problems _____
 Excessive Scarring _____ Fever Blisters/Cold Sores _____ Liver/Gall Bladder/Yellow Jaundice _____
 Mental Illness _____ Seizures/Epilepsy _____ Skin Infections/Irritations/Rashes _____
 Depression _____ Dry eyes/vision _____ Other _____

TURN OVER

