

GOLD COAST PLASTIC SURGERY ^{LLC}
CONSULTATION AND MEDICAL HISTORY

Name _____ Today's Date _____

Date of Birth _____ Phone #: Home Cell Work _____

How were you referred to us? _____ Name of family members who are our patients _____

Check the procedures in which you are interested: Facelift Rhinoplasty Chin Eyelids Septoplasty
Chemical Peel Dermabrasion Laser Resurfacing Microdermabrasion Scar Revision Otoplasty
Hair Transplants Laser Hair Removal Botox Injection Juvederm Injection Silikon 1000 Mohs Closure
Facial Reconstruction Removal of Cyst, Warts, Moles, Etc. Other _____

When did you begin to consider surgical correction? _____

Why have you decided to have it done at this point in time? _____

Have you consulted with any other doctors about this? (When?) _____

Have you discussed this surgery with your family? Yes No Are they agreeable? Yes No

Have you had any previous cosmetic, plastic or reconstructive surgery? Yes No

When, and what, was done? _____
Who performed surgery? _____ Where was it performed? _____
Were you satisfied with the results? _____ If not, why? _____

If injury, describe injury: _____ Date of injury _____

Place of injury _____ Treatment received _____

When? _____ Complication of injury: _____

Has anyone in your family or close friend had cosmetic, plastic, or reconstructive surgery? Yes No
What was done? _____ By whom? _____

Have you had any other prior surgery? (Check and date what was done & when it was performed)
Head & Neck _____ Skin _____ Teeth/Gums _____ Chest _____
Abdomen _____ Reproductive System _____ Back/Arms/Legs _____
Other _____

Did you have a normal recovery? Yes No Did the result meet your expectations? Yes No
If no, please explain _____

When was your last physical examination? _____

Who is your primary physician? _____ Telephone _____

Address _____ City _____ State _____

May we have your permission to consult with your physician? Yes No

MEDICAL HISTORY (CIRCLE APPROPRIATE RESPONSE)

No Yes Are you allergic to any medication, cream, tape, make-up, etc? Please list: _____

No Yes Do you have/had nasal allergies, 'sinus problems', asthma or hay fever? (Explain below) _____

No Yes Have you ever received local anesthesia ("Novocaine, Xylocaine") by a dentist or doctor? _____

No Yes Did you have a "reaction" to any anesthesia? Explain _____

No Yes Do you or any family members have: (indicate who) _____

Heart trouble _____ Excessive bleeding tendencies _____

High Blood Pressure _____ Diabetes _____

Thyroid Problems _____ Psychiatric or 'nerve' problems _____

Excessive bruising _____ Excessive Scarring _____

Delayed or poor healing _____ Other _____

TURN OVER → → →

