[liv] PLASTIC SURGERY

By Andrew Ress, M.D.

PATIENT INFORMATION

NAME _____ SS# _____ HOME PHONE _____

ADDRESS _____ CELL PHONE _____

CITY _____STATE _____ ZIP CODE _____

DATE OF BIRTH _____ AGE _____ SEX _____ HEIGHT _____ WEIGHT _____MARITAL STATUS _____

ETHNICITY (CIRCLE ONE): WHITE / HISPANIC / BLACK OR AFRICAN AMERICAN / ASIAN / REFUSE TO REPORT / OTHER _____

LANGUAGES SPOKEN (CIRCLE): ENGLISH / SPANISH / INDIAN / RUSSIAN / FRENCH / PORTUGUESE / OTHER: _____

EMPLOYER _____ OCCUPATION _____

BUSINESS PHONE _____ EMAIL _____

SPOUSE'S NAME _____ PHONE _____

EMERGENCY PERSON _____ PHONE _____

PHYSICIAN/INTERNIST _____ PHONE _____

PHARMACY NAME _____ PHONE _____

Reason for Visit _____

HAVE YOU EVER CONSULTED A PLASTIC SURGEON? (PLEASE GIVE DETAILS) _____

_____

HAVE YOU EVER HAD PLASTIC SURGERY? (PLEASE DESCRIBE, INCLUDING DATES) _____

_____

WERE YOU SATISIFIED WITH YOUR PROCEDURE(S)? _____

I WOULD LIKE INFORMATION ON:

[ ] Liposuction	[ ] Breast Augmentation	[ ] Tummy Tuck	[ ] Breast Lift / Reduction
[ ] Laser Surgery	[ ] Nasal Surgery	[ ] Scar Revision	[ ] Anti-Aging Treatment
[ ] Facial Implants	[ ] Age Spot Removal	[ ] Facelift	[ ] Weight Loss
[ ] Browlift	[ ] Facials	[ ] Midface Lift	[ ] Eyelid Surgery
[ ] Endoscopic Facial Surgery	[ ] Otoplasty	[ ] Permanent Makeup	[ ] Other: _____

PLEASE TELL US HOW YOU HEARD ABOUT OUR PRACTICE:

[ ] Physician: _____ [ ] Friend: _____ [ ] Patient: _____

[ ] Website: _____ [ ] Paper/Magazine: _____ [ ] Other: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

My medical condition to be evaluated by Ress Plastic Surgery arose from:

[ ] my workplace [ ] an automobile accident ( ) an injury related to someone else's negligence [ ] none of the above

I have an attorney representing me regarding my medical condition: [ ] NO [ ] YES:

Attorney Name and Firm:

_____

IN THE PAST TWO WEEKS, HAVE YOU TAKEN ANY OF THE FOLLOWING (PLEASE CIRCLE):

ACCUTANE	ADVIL	AGGRENOX	ALEVE	ALKA SELTZER
ANACIN	ARTHRITIS PAIN FORMULA	ACRIPTION	ASPIRIN TABLETS	BAYER
BUFFERIN	CAMA ARTHRITIS RELIEVER	CELEBREX	CONDROIDIN	COUMADIN
DOANS PILLS	ECHINACEA	ECOTRIN	EMPRIN COMPOUND	EXCEDRIN
FISH OIL	FIORINAL	GREEN TEA	GINSENG	GINKO
GLUCOSAMINE	GOODIES	INDOCIN	MIDOL	MOTRIN
NAPROSYN	NORGESIC	NUPRIN	PENTASA	PEPTO-BISMAL
PLAVIX	PRESISTIN	ST. JOHN'S WORT	TRIGESTIC	VANQUISH
VICOPROFEN	VITAMIN C (1000 mg daily)	VITAMIN E (ok multivitamin)	WARFARIN	4WAY COLD TABLETS

Medical History

FOR YOUR OWN SAFETY, PLEASE PROVIDE US WITH A *COMPLETE* MEDICAL HISTORY

Reason for visit _____

ALLERGIES TO MEDICATIONS:

CURRENT MEDICATIONS	**USED FOR**	**DOSING**

SURGERIES	**YEAR**	**COMPLICATION**

RESERVED FOR PHYSICIAN NOTES

REVIEW OF SYSTEMS

GENERAL

[ ] Y [ ] N Fever
[ ] Y [ ] N Weight Loss
[ ] Y [ ] N Decreased Appetite
[ ] Y [ ] N Excessive Fatigue

EYES

[ ] Y [ ] N Wear Glasses
[ ] Y [ ] N Date of last exam
[ ] Y [ ] N Glaucoma
[ ] Y [ ] N Cataracts
[ ] Y [ ] N Infections
[ ] Y [ ] N Injuries
[ ] Y [ ] N Dry Eye Symptoms?

EAR, NOSE, THROAT, MOUTH

[ ] Y [ ] N Wear hearing aids
[ ] Y [ ] N Nose Bleeds
[ ] Y [ ] N Congestion
[ ] Y [ ] N Inability to smell
[ ] Y [ ] N Cold sores
[ ] Y [ ] N Hoarseness
[ ] Y [ ] N Difficulty swallowing

CARDIOVASCULAR

[ ] Y [ ] N High blood pressure
[ ] Y [ ] N Irregular pulse
[ ] Y [ ] N Heart murmur
[ ] Y [ ] N High cholesterol
[ ] Y [ ] N Swelling hands/feet
[ ] Y [ ] N Leg pain while walking
[ ] Y [ ] N Pacemaker

PSYCHIATRIC

[ ] Y [ ] N Depression
[ ] Y [ ] N Anxiety
[ ] Y [ ] N Mental Illness
[ ] Y [ ] N Psychiatric meds?
[ ] Y [ ] N Sleeping difficulty

RESPIRATORY

[ ] Y [ ] N Asthma
[ ] Y [ ] N Emphysema

GASTROINTESTINAL

[ ] Y [ ] N Ulcer / Gastritis
[ ] Y [ ] N Liver disease/ Hepatitis
[ ] Y [ ] N Reflux

BREAST

[ ] Y [ ] N Menopause
[ ] Y [ ] N Uterine/Cervical cancer
[ ] Y [ ] N Breast Cancer
[ ] Y [ ] N Abnormal Mammograms
[ ] Y [ ] N Birth control method _____
_____
Last mammogram date

ALLERGIC/IMMUNOLOGIC

[ ] Y [ ] N Food allergies
[ ] Y [ ] N Inhalant allergies
[ ] Y [ ] N Immune disorders
[ ] Y [ ] N Drink alcoholic drinks
How much? _____
[ ] Y [ ] N Smoke cigarettes?
How much? _____
[ ] Y [ ] N Exercise regularly
Type? _____
[ ] Y [ ] N Other Medical problems
_____
_____
[ ] Y [ ] N Living Will
[ ] Y [ ] N Advanced Directive Power of Attorney

ENDOCRINE

[ ] Y [ ] N Diabetes
[ ] Y [ ] N Thyroid disease
[ ] Y [ ] N Hormone problems

HEMATOLOGICAL/LYMPHATIC

[ ] Y [ ] N Anemia
[ ] Y [ ] N Bleeding tendencies
[ ] Y [ ] N Phlebitis
[ ] Y [ ] N History of blood clots?
[ ] Y [ ] N Blood transfusion
When? _____

MUSCULOSKELETAL

[ ] Y [ ] N Back/neck pain
[ ] Y [ ] N Arm/leg pain
[ ] Y [ ] N Joint pain/swelling
[ ] Y [ ] N Arthritis
[ ] Y [ ] N Broken bones
[ ] Y [ ] N Osteoporosis

SKIN

[ ] Y [ ] N Skin Cancer types

NEUROLOGICAL

[ ] Y [ ] N Fainting/blackout spells
[ ] Y [ ] N Seizures
[ ] Y [ ] N Memory problems
[ ] Y [ ] N Facial weakness
[ ] Y [ ] N Headaches
[ ] Y [ ] N Stroke
[ ] Y [ ] N Muscle weakness
[ ] Y [ ] N Numbness/tingling
[ ] Y [ ] N Tremors/hand shaking

ENDOCRINE

[ ] Y [ ] N Breast Cancer
[ ] Y [ ] N Other Cancers
[ ] Y [ ] N Mental Illness
[ ] Y [ ] N Genetic types of disorders
[ ] Y [ ] N Children have medical problems?
If yes, what kind(s)?
_____

HOW MANY CIGARETTES OR VAPOR HAVE YOU SMOKED IN THE LAST YEAR?

[ ] NONE or _____