CONTOURA FACIAL PLASTIC SURGERY
PATIENT INFORMATION

NAME: _____ TODAY'S DATE:_____

DOB: _____ SEX:_____ MARITAL STATUS:_____

ADDRESS: _____

CITY:_____ STATE:_____ ZIP:_____

HOME #:_____ CELL#:_____ WORK #: _____

E-MAIL ADDRESS: _____

SSN (optional):_____ OCCUPATION:_____

Pharmacy:_____ Pharmacy phone number:_____

How did you hear about us:_____

EMERGENCY CONTACT PERSON & TEL. NO._____

In order to respond to all of our patient's needs and to provide the highest quality of care, please check the areasof the face that concern you:

Face/Facial Lines_____ Neck_____Eyebrows_____ Upper Eyes_____ Lower Eyes_____ Puffy Eyes_____

Cheeks_____ Chin _____ Lips _____ Ears_____ Skin_____ Nose_____ Function of your Nose_____

Lost facial volume_____ Scars_____

Are you concerned with a Lesion on your Face? _____

Are you interested in non surgical treatments (ie Ultherapy, Laser , Skin Care)?_____

Are there any areas of your body that you would you like to improve or enhance?

____Breasts ____ Thighs/Legs ____Arms ____Torso (Belly, Love Handles, Back)

Are you interested in scheduling a consultation with a body surgeon? _____

SURGERY/MEDICALQUESTIONNAIRE

Please tell us about your general medical history:_____
_____
_____

Please list past surgical procedures: _____ _____
_____
_____

Family history of bleeding disorders or problems with anesthesia:_____
_____

PRIMARY CARE physician name :_____

MEDICATIONS (include nonprescription drugs, vitamins, and herbal supplements)

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Drug Allergies _____

PLEASE TURN TO BACK PAGE

MEDICAL, SURGICAL AND SOCIAL HISTORY (CONTINUED)

YES	NO		YES	NO	
____	____	DO YOU SMOKE**?**	____	____	HAVE YOU EVER SMOKED?
If yes, how much?_____Packs			____	____	Alcohol Use? If Yes, how much?_____
____	____	Do you suffer from dizziness?	____	____	Treatment for Alcohol or drug dependency problems?
____	____	Blackout spells?			
____	____	Dry eyes?	____	____	Do you have HIVor AIDS?
____	____	Black or bloody stools?	____	____	Do you have Hepatitis A, B or C? (Circle which one)
____	____	Weight loss?	____	____	Do you get irritated easily?
____	____	Weight gain?	____	____	Have you ever been under the care of a psychiatrist or psychologist?
____	____	Fever blisters?			
____	____	Do you bruise easily?	____	____	Do you have abnormal or heaving bleeding?
		from anywhere in your body?	____	____	Do you suffer from frequent headaches?
____	____	Anemia or blood problems?	____	____	Have you been treated for genital blisters?
____	____	Do you have weakness in your arms or legs?	____	____	Do you have an STD?
____	____	Numbness anywhere?	____	____	Have you ever had any kind of problems (nausea, trouble with recovery, etc) with any kind of anesthesia (local general, twilight)?
____	____	Are you allergic to ANYTHING?			
			____	____	Have you ever had MRSA (staph infections)?
____	____	Have you been hospitalized within 24 months?	____	____	Have you had contact with persons with staph?

____ ____ Have you been on antibiotics within the past 12 months?

Yes____ No ____ Do you authorize and give consent to have the recommended diagnostic, medical, surgical, photographic and aesthetic services that our physicians or staff deem beneficial to you while under our care?

Yes____ No____ Have you read the patient's Bill of Rights?

I have received information regarding the providers of care in this organization.
I have been offered a copy of the Patient's Bill of Rights and Responsibilities.
I have received information regarding the grievance process.

Signed: _____ Today's Date: _____

By signing the above, I affirm that all information I have provided on this questionnaire is truthful and accurate.

Thank you for taking the time to answer these questions. They are very important in our assessment. Please write any additional questions anywhere on this sheet so that they may be addressed at the time of your consultation.

ON BEHALF OF DR. GARCIA AND HIS STAFF, WELCOME TO CONTOURA PLASTIC SURGERY!

Revised 4/14/16 CJS