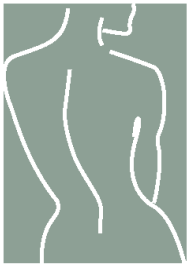

**Willow Bend Cosmetic Surgery**
5824 West Plano Parkway, Suite 101
Plano, Texas 75093
**972.267.3223**

# PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

Preferred Name: _____

Gender: □ Male □ Female DOB: _____ Age: _____ SS#: _____

Marital Status: □ Single □ Married □ Divorced □ Widow

Street Address: _____Apartment/Suite#: _____

City: _____ State: _____ Zip: _____

Home/Cell Phone#: _____ Work Phone#: _____

E-mail Address: _____

Referred By: □ Online Search Engine □ Advertising □ Other: _____

Work/School Status: □ Full-time □ Part-time □ Retired □ Unemployed

## RESPONSIBLE PARTY

Who will be responsible for this account: □ Self □ Spouse □ Parent □ Other: _____

Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home/Cell Phone#: _____ Work Phone#: _____

## IN CASE OF EMERGENCY

Name: _____ Phone#: _____

Relationship: _____

## REASON FOR VISIT

□ Facelift/Necklift □ Nose Surgery □ Liposuction

□ Eyelid Surgery □ Lip Augmentation □ Breast Augmentation

□ Endoscopic Browlift □ Botox/Facial Fillers □ Laser Skin Resurfacing

□ Cheek/Chin Implant(s) □ Other: _____

**Patient Name**_____ **Date** _____

# HEALTH HISTORY

**To our patients:** As your cosmetic surgery practice, our primary concern is your overall health. Health problems you may have or medications you are taking can play an important role in the care you will be receiving.

Overall health: □ Good □ Fair □ Poor Height:_____ Weight:_____

**Medical History:** Please check any of the following conditions which YOU have had or presently have:

□ AIDS or HIV
□ Arthritis or joint disease
□ Artificial joints
□ Asthma
□ Blood disorder
□ Blood transfusion
□ Bronchitis
□ Bruise easily
□ Cancer, tumor or growth
□ Cardiac pacemaker
□ Chemotherapy
□ Chest pain
□ Contact lenses
□ Convulsions, epilepsy
□ Damaged heart valves/MVP
□ Diabetes
□ Difficulty breathing
□ Emphysema
□ Eye disease/glaucoma
□ Fainting spells
□ Gallbladder trouble
□ Habit forming/illegal drugs
□ Hayfever/sinus problems
□ Heart attack
□ Heart murmur
□ Heart surgery
□ Hemophilia
□ High blood pressure
□ Immunological disorder
□ Irregular heart beat
□ Jaundice, hepatitis or liver disease
□ Kidney trouble; dialysis
□ Low blood sugar
□ Low blood pressure
□ Mental health problem
□ Malignant hyperthermia
__ dark or chocolate urine
__ muscle/neuromuscular disorder
__ muscle spasms
__ unanticipated fever following anesthesia or exercise
□ Muscular dystrophy/disorders
□ Pain & clicking of jaw
□ Radiation therapy
□ Sexually transmitted disease
□ Stomach ulcers
□ Stroke
□ Thyroid trouble
□ Tuberculosis

Have you ever had any serious illness not listed? (Please describe) _____

_____

| | YES | NO |
|---|---|---|
| Have you ever been told you are at risk for malignant hyperthermia? ..... | ☐ | ☐ |
| Has a family member ever been told they are at risk for malignant hyperthermia?..... | ☐ | ☐ |
| Do you have a family history of unexpected death(s) following general anesthesia or exercise?..... | ☐ | ☐ |
| Have there been any changes to your general health in the past year? ..... | ☐ | ☐ |
| Are you under the care of a physician? Date of last visit:_____ | ☐ | ☐ |
| If so, for what are you being treated?_____ | | |
| Have you had any illness, operation or been hospitalized in the past? If so, describe._____ | ☐ | ☐ |
| Is the condition we are seeing you for today due to an accident? ..... | ☐ | ☐ |

**General Surgical History:**

□ Appendectomy □ Pacemaker □ CABG □ Gall Bladder
□ Tonsillectomy □ Coronary Stent □ Neck/Back □ Other: _____

**Please list any previous cosmetic procedures:**

| Cosmetic Procedure: | Date: |
|---|---|
| | |
| | |
| | |
| | |

*Please use attached blank form if additional space is needed.

**Patient Name**_____ **Date** _____

## ALLERGIES

Are you allergic to **Penicillin**?_____What is the reaction?_____

| **Other allergies:** | **Reaction:** |
|---|---|
| | |
| | |
| | |
| | |

## MEDICATIONS

| Are you taking or have you ever taken any of the following: | **YES** | **NO** |
|---|---|---|
| **Bisphosphonates**? (used to treat osteoporosis or breast cancer) For example: | | |
| Boniva, Fosamax, Actonel, Zometa, Xgeva ..... | ☐ | ☐ |
| **Anticoagulants**? Coumadin, Warfarin, Aspirin, Plavix?..... | ☐ | ☐ |

**Please list any medications you are currently taking:**

| **Name of Drug:** | **Strength:** | **Times per day:** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

*Please use attached blank form if additional space is needed.

## LIFESTYLE

Occupation: _____

Exercise? ☐YES ☐NO If yes, Type: _____ Frequency:_____ Hours per week: _____

Tobacco Use? ☐Never ☐Current ☐Former, Year quit?_____

Tobacco type: _____ How many per day: _____ Years used: _____

Caffeine: ☐YES ☐NO Type:_____ Amount: _____

Alcohol: ☐YES ☐NO Amount: _____

## WOMEN

| | **YES** | **NO** |
|---|---|---|
| When was your last menstrual period? _____ | | |
| Is there a possibility that you may be pregnant?..... | ☐ | ☐ |
| If yes, estimated delivery date:_____ | | |
| Are you nursing? ..... | ☐ | ☐ |
| *Are you taking birth control pills? ..... | ☐ | ☐ |

**** PRECAUTION:*** *If an antibiotic is prescribed for you, and you are currently taking birth control pills, please be aware that the drug prescribed may interfere with the effectiveness of your birth control. The result could be an unplanned or unexpected pregnancy.* ***Discuss using other methods of birth control with your prescribing doctor.***

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above are answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions I have made in the completion of this form.

Signature of Patient/Patient's Guardian: _____ Date: _____

**Patient Name**_____ **Date** _____

## MEDICATIONS

| Name of Drug: | Strength: | Times per day: |
|---|---|---|
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## COSMETIC PROCEDURES

| Cosmetic Procedure: | Date: |
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