ROUSSO FACIAL PLASTIC SURGERY CLINIC, P.C.

CONSULTATION AND MEDICAL HISTORY

Name ___________________________ Date of Birth __________________ Today's Date _________________

Address: Home ____

Street City State Zip Telephone

Cell Phone: ______________________Email Address: ____

Business ____

Street City State Zip Telephone

Marital Status: ☐S ☐M ☐D ☐W Spouse's Name _______________________________________

Your Occupation/Employer _______________________ Spouse's Occupation/Employer ______________________

How were you referred to us? ____

Name of family members who are our patients ____________________________________

In which surgical procedure(s) are you interested in? (Please select)

☐Facelift ☐Rhinoplasty ☐Chin ☐Eyelids

☐Septoplasty ☐Chemical Peel ☐Dermabrasion ☐Laser Resurfacing

☐Microdermabrasion ☐Scar Revision ☐Protruding Ears ☐Hair Transplants

☐Laser Hair Removal ☐Botox Injection ☐Facial Reconstruction ☐Removal of Cyst/Warts/Moles

☐Removal of Brown Spots Removal of Facial Veins ☐Micro Laser Peel ☐Restylane/Sculptra/Radiesse

☐Other __________________________

When did you begin to consider surgical correction? ________________________

Why have you decided to have it done at this time? _________________________

Have you consulted any other doctor about this? ☐Y ☐N When? __________________________

Have you discussed this surgery with your family? ☐Y ☐N Are they agreeable? ☐Y ☐N

Have you had any previous cosmetic, plastic or reconstructive surgery? ☐Y ☐N

When, and what, if anything was done? _____________________Who performed the surgery? __________________

Where was it performed?____

Were you satisfied with the result? ☐Y ☐N If not, why? _________________________________ If injury, describe injury ______________________________________

Date of injury _________________ Place of injury ________________Treatment received ____________________

Do you have problems breathing through your nose? ☐Y ☐N Do you have sinus problems? ☐Y ☐N

Have you had nasal trauma? ☐Y ☐N When? __________________ Describe: ______________________

Has anyone in your family or a close friend had cosmetic, plastic or reconstructive surgery? ☐Y ☐N

What was done? ______________________________By Whom? ____________________________

Have you had any other prior surgery? ☐Y ☐N When was it performed? _________________________

Head and neck: ________________Skin _________________ Teeth/Gums ____________________________

Chest ________________Abdomen ___________________ Reproductive system ____________________

Back/Arms/Legs _________________ Other_____________________________

Did you have a normal recovery? ☐Y ☐N Did the results meet your expectations? ☐Y ☐N

If no, explain ____

Who is your primary physician? ____

Address ____

Street City State Zip Telephone

May we have your permission to consult with your physician? ☐Y ☐N

MEDICAL HISTORY (mark appropriate response)

☐No ☐Yes Are you now taking any drugs or medications? (How often?)
List them if you can _____________________

☐No ☐Yes Are you allergic to any medication, cream, tape, make-up, etc?
List them if you can _____________________

☐No ☐Yes Have you ever received local anesthesia ("Novocaine, Xylocaine") by a dentist or a 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 bruisability_____________________ Excessive Scarring _____________________ Delayed or poor healing _____________________ Other _____________________

☐No ☐Yes Do you have any history of bleeding: (indicate which)
From the nose _____________________ In the urine _____________________
Vomiting Blood _____________________From the rectum _____________________
Cough up Blood _____________________Other _____________________

☐No ☐Yes Do you have or have you had nasal allergies, "sinus problems", asthma or hay fever? (explain)
____

☐No ☐Yes Has a doctor ever said you had "heart trouble"? Explain _____________________

☐No ☐Yes Do you have "stomach trouble"? ulcers? Explain _____________________

☐No ☐Yes Do you have or have you had chest or lung problems? Explain _____________________

☐No ☐Yes Have you ever had liver, gall bladder trouble or "yellow jaundice"? Explain _____________________.

☐No ☐Yes Have you been bothered by kidney or bladder problems? Explain _____________________

☐No ☐Yes Do you have frequent skin infections, irritation or rashes? Explain _____________________

☐No ☐Yes Have you ever had "fever blisters" or "cold sores" or canker sores on your face, lips or in your mouth Or Genital Herpes? Explain _____________________

☐No ☐Yes Do you often have severe headaches or dizzy spells? _____________________

☐No ☐Yes Has any part of your body ever been paralyzed or numb? Explain _____________________

☐No ☐Yes Did you ever have a convulsion or seizure? Explain _____________________

☐No ☐Yes Were you ever told you had any venereal disease or AIDS? Explain _____________________

☐No ☐Yes Were you ever treated for anemia or any problems with your blood? Explain _____________________

☐No ☐Yes Have you ever taken hormones or thyroid medication? Explain _____________________

☐No ☐Yes Do you smoke?

☐No ☐Yes Do you drink two or more alcohol drinks per day?

☐No ☐Yes Have you ever received treatment for abuse of alcohol or drugs? Explain _____________________

☐No ☐Yes Do you often get depressed?

☐No ☐Yes Have you ever received medical treatment for a "nervous breakdown"? Explain _____________________

☐No ☐Yes Have you ever been under the care of a psychiatrist or a psychologist? Explain _____________________

☐No ☐Yes Do you have any other medical problems that have not been covered? Explain _____________________

☐No ☐Yes Do you accept the fact that every medical and surgical treatment is associated with risks & imponderables?

Patient Signature ____ Date ___________________________

Reviewed by ____ Date ___________________________

The information you have provided is essential in our comprehensive evaluation of your case. Thank you,

ROUSSO FACIAL PLASTIC SURGERY CLINIC, P.C.