

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?

Signature _____ Date _____

Reviewed by: _____

Patient

Date _____

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

Thank you,

ROUSSO FACIAL PLASTIC SURGERY CLINIC, P.C.