

# Institute of Aesthetic Surgery at Celebration

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**In order to better serve you, please print the following requested information.**

**Thank you!**

**Patient's Full Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Parent's Name (if a child) \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

SSN# \_\_\_\_\_ M or F \_\_\_\_\_

(If patient is a child, give SSN# for: )

Mom \_\_\_\_\_ Dad \_\_\_\_\_ Child \_\_\_\_\_

Employer/Occupation \_\_\_\_\_

E-mail address: \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ **Relationship** \_\_\_\_\_

Contact Phone # \_\_\_\_\_

Spouse's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ SSN# \_\_\_\_\_ Work # \_\_\_\_\_

## **How did you hear about our practice?**

\_\_\_\_ Magazine (name of magazine) \_\_\_\_\_

\_\_\_\_ Internet (Inside Central Florida\_\_ ) (WESH channel 2\_\_ ) (Our Website \_\_\_\_ )

\_\_\_\_ TV Commercial \_\_\_\_\_

\_\_\_\_ Local Newspapers.....Southwest Bulletin \_\_\_\_\_

\_\_\_\_ Physician (Name & Address) \_\_\_\_\_

\_\_\_\_ Family member or friend (Name/Address) \_\_\_\_\_

What other plastic surgeons or dermatologists have you seen in the past ? \_\_\_\_\_

Which other plastic surgery or dermatology procedures have you had in the past? \_\_\_\_\_

What Skin Care regimen are you using right now (list products) \_\_\_\_\_

Please list your favorite hobbies? \_\_\_\_\_

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date: \_\_\_\_\_

**Can we send other family members or acquaintances information about our services?**

Name	Address/Phone#	Type of Information
_____	_____	_____
_____	_____	_____
_____	_____	_____

**What services are you interested in? (check all that apply)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Laser Skin Rejuvenation | <input type="checkbox"/> Breast Reduction             |  |
| <input type="checkbox"/> Facelift                | <input type="checkbox"/> Chin Implant                 | <input type="checkbox"/> Facials/Masks       |
| <input type="checkbox"/> Eyelidplasty            | <input type="checkbox"/> Breast Lift                  | <input type="checkbox"/> Microdermabrasion   |
| <input type="checkbox"/> Tummy Tuck              | <input type="checkbox"/> Laser Hair Removal           | <input type="checkbox"/> Skin Care Regimen   |
| <input type="checkbox"/> Rhinoplasty             | <input type="checkbox"/> Brown Spot Removal           | <input type="checkbox"/> Cellulite Treatment |
| <input type="checkbox"/> Liposuction             | <input type="checkbox"/> Laser Vein Treatment         | <input type="checkbox"/> Permanent Makeup    |
| <input type="checkbox"/> Breast Enhancement      | <input type="checkbox"/> Botox                        |  |
| <input type="checkbox"/> Body Contouring         | <input type="checkbox"/> Restylane/Juvederm Injection |  |

**While you may go to our website to see any upcoming specials, we occasionally have seminars and special events and would like to email you to let you know. Please enter your email address:**

E-Mail \_\_\_\_\_

**Family Physician:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Past Medical History:** List all illness requiring doctor's care in the past

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Surgical History:** List all operations, including minor procedures

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Date \_\_\_\_\_

**ALLERGIES:**

Name \_\_\_\_\_ Reaction: \_\_\_\_\_

Name \_\_\_\_\_ Reaction: \_\_\_\_\_

Name \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergic to Latex? Y or N      Allergic to Iodine: Y or N

**Current List of Medication:**

Name \_\_\_\_\_ Dose \_\_\_\_\_ How Often \_\_\_\_\_

Name \_\_\_\_\_ Dose \_\_\_\_\_ How Often \_\_\_\_\_

Name \_\_\_\_\_ Dose \_\_\_\_\_ How Often \_\_\_\_\_

Name \_\_\_\_\_ Dose \_\_\_\_\_ How Often \_\_\_\_\_

Name \_\_\_\_\_ Dose \_\_\_\_\_ How Often \_\_\_\_\_

**Have any of your blood relatives been diagnosed with the following conditions?**

\_\_\_ Anesthesia Complications: Describe \_\_\_\_\_

\_\_\_ Cancer : Type \_\_\_\_\_

\_\_\_ Diabetes: \_\_\_ type 1 \_\_\_ type 2 \_\_\_\_\_

\_\_\_ Heart Disorder: Diagnosis \_\_\_\_\_

\_\_\_ (high/low) Blood Pressure \_\_\_\_\_

\_\_\_ Bleeding Disorder \_\_\_\_\_

**Do you now, or have you ever used tobacco products?** \_\_\_yes \_\_\_no

If yes, please describe: Type \_\_\_\_\_

Number of years: \_\_\_\_\_

The most you ever used per day: \_\_\_\_\_

If you have quit using tobacco, when did you do so? \_\_\_\_\_

**Please list any surgeries you have had in the past:**

**Name of Surgery:**

**Date of Surgery:**

**Any Complications:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date: \_\_\_\_\_

**CHECK ONLY THOSE CONDITIONS THAT APPLY TO YOU, NOW OR IN YOUR PAST.**

**SURGICAL COMPLICATIONS:**

- |  |   |
|--|---|
| <input type="checkbox"/> Excessive Skin  | <input type="checkbox"/> Complications from anesthesia      |
| <input type="checkbox"/> Active skin wounds  | <input type="checkbox"/> Post operative shortness of breath |
| <input type="checkbox"/> Persistent or recurrent skin infections                       | <input type="checkbox"/> Post operative fevers              |
| <input type="checkbox"/> Complication with post operative healing wounds or dehiscence | <input type="checkbox"/> Nausea or vomiting                 |
| <input type="checkbox"/> Bleeding complications from previous surgeries (blood clots)  | <input type="checkbox"/> History of post-op complications   |
| <input type="checkbox"/> Thrombotic episodes from previous surgeries                   |   |
| <input type="checkbox"/> Post operative swelling of limbs                              |   |

**SKIN:** history of:

- |   |   |
|---|---|
| <input type="checkbox"/> Abscess            | <input type="checkbox"/> Suspicious lesions           |
| <input type="checkbox"/> Skin cancers       | <input type="checkbox"/> Suspicious or changing moles |
| <input type="checkbox"/> Skin color changes |   |

**HEENT:** history of:

- |   |   |
|---|---|
| <input type="checkbox"/> Dry Eyes   | <input type="checkbox"/> Nasal deformity          |
| <input type="checkbox"/> Eye surgery  | <input type="checkbox"/> Facial fracture          |
| <input type="checkbox"/> Nasal obstructions (difficulty breathing through nose) | <input type="checkbox"/> Diplopia (double vision) |
| <input type="checkbox"/> Recent head trauma                                     | <input type="checkbox"/> Changes in vision        |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Difficulty closing eyes  |

**HEART:** history of:

- |  |   |
|--|---|
| <input type="checkbox"/> Arrhythmias                           | <input type="checkbox"/> Murmur                 |
| <input type="checkbox"/> Myocardial infarctions (heart attack) | <input type="checkbox"/> Cardiovascular disease |
| <input type="checkbox"/> Coronary or peripheral artery disease | <input type="checkbox"/> Hypertension           |
| <input type="checkbox"/> Varicosities                          | <input type="checkbox"/> Stroke                 |

**PULMONARY:** history of:

- |   |  |
|---|--|
| <input type="checkbox"/> Pulmonary disease  | <input type="checkbox"/> Tobacco use         |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Asthma or wheezing |  |

**GASTROINTESTINAL SYSTEM:** history of:

- |   |  |
|---|--|
| <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Gastrointestinal problems |
| <input type="checkbox"/> Liver disease      |  |

**GENITOURNINARY SYSTEM:** history of:

- Genitourninary problems

**NEURO-PSYCH:** history of:

- |  |   |
|--|---|
| <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Psychological problems |
|--|---|

(Continued)

Name of Patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date: \_\_\_\_\_

**HEMATOLOGIC/LYMPHATIC:** history of:

\_\_\_ Hematological disorders

\_\_\_ Spontaneous or prolonged bleeding (w/minor trauma)

\_\_\_ Bruise easily

**ENDOCRINE/BREAST:** history of:

\_\_\_ Breast cancer

\_\_\_ Breast deformity

\_\_\_ Diabetes

\_\_\_ Breast skin changes

\_\_\_ Breast masses

\_\_\_ Back pain from enlarged breast

\_\_\_ Breast pain

\_\_\_ Shoulder pain from enlarged breast

\_\_\_ Thyroid disease

**GYNECOLOGICAL:**

\_\_\_ Recent Pregnancy

The above information is correct to the best of my knowledge and I have signed below stating this.

\_\_\_\_\_  
Signature of Patient (If 18 or older)

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date Signed