Dev Wali, MD
Cosmetic and Reconstructive Plastic Surgery

Patient name: _____

Age: _____

Occupation: _____

Allergies to medications: _____

Please list any medical conditions being treated by a doctor now or in the past.

_____

Please list any surgical procedures you have ever had major or minor.

_____

Please list any medication you are taking now or have taken in the past.

_____

Have you ever smoked? If so, how much and for how long?

_____

How often do you have an alcoholic beverage?

_____

If female, is there any possibility you may be pregnant? Are you taking birth control?

_____

If female, how many times have you been pregnant? How many children do you have?

_____

Have you ever received Botox, or cosmetic surgery in the past? If so, when?

_____

What specific questions do you wish to be answered with this consultation?

_____

Please let us know the name of your referring physician or other referral source.

_____

I attest to the above information being true to the best of my knowledge.

Signature: _____

Date: _____