HOLZAPFEL AND LIED PLASTIC SURGERY
CONSULTATION AND MEDICAL HISTORY

Name: _____ Today's Date: ____/____/____
Last First Middle Initial

Preferred method of being addressed by the office staff:

By (circle one): Mr. Miss Ms. Mrs. Dr. First name or nick name: _____

PERSONAL DATA

Birth Date: ____/____/____ Age: _____ Social Security # _____ Sex: M / F / T

Marital Status: M / D / S / W / Separated Spouse's Name: _____ # of Children: _____

Occupation: _____ Employer: _____

Phone Numbers: (Please * preferred #)

( ) Home: _____ ( ) Cell: _____

( ) Work: _____ Fax: _____

Emergency Contact: _____ Emergency Phone: _____

Email address: _____

Would you like to receive email specials? Y / N

Addresses

Primary Address

_____
Street Apt #

_____
City, State, Zip Code

Secondary Address

_____
Street Apt #

_____
City, State, Zip Code

How did you hear about our office? _____

Referred by: _____ May we correspond with them: Y / N

Which of the following procedures interest you? (Please circle all that apply)

Arm lift	Botox / Dysport / Xeomin	Breast Augmentation	Breast Lift	Breast Reduction
Breast Reconstruction	Buttock lift	Cheek Implants	Chemical Peel	Chin Implant
Diet	Eyelids	Face or Neck Lift	Fat transfer	Forehead Lift
Hair Transplant	Laser Treatment	Lip Augmentation	Liposuction Body	Liposuction Face
Male Breast Reduction	Protruding Ears	Rhinoplasty (nose)	Scar Revision	Thigh Lift
Tummy Tuck	Wrinkle Filler	Vein Treatment / Sclerotherapy		
Removal cyst, warts, moles, etc.		Other: _____		

Do you have any interest in **Coolsculpting** Y / N if so what areas? _____

Have you consulted other physicians concerning this? Y / N

Is having surgery your idea or someone else's? _____

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

MR# _____

CHECK IF YOU HAVE OR HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST

ILLNESS	YES	ILLNESS	YES
Allergies- (Seasonal)		Fracture – **Type**:	
Anemia		GERD / Reflux / Indigestion	
Aneurysm- **Type:**		Glaucoma	
Anxiety		Heart Trouble- **Type:**	
Arthritis		Hepatitis B or C / Jaundice	
Autoimmune Disease- Type:		Hernia- **Type:**	
Asthma		High Blood Pressure	
Bleeding Disorder / Clotting Disorder		High Cholesterol	
Blood Clots **Legs / Lungs**		HIV	
Bruising		Kidney Disease	
Bowel trouble / IBS / Constipation		Kidney Infections / Stones	
Breast Cancer		Osteoporosis	
Cancer **enter type:**		Psychiatric Illness	
Chronic Lung Disease		Rheumatic Fever	
Chronic Sinus Infections		Seizures	
Chronic Pain- **Type:**		Sleep Apnea	
Cirrhosis		Stroke	
Clotting Disorder		Thyroid Problems	
Depression		Urinary Incontinence: **(see below)**	
Diabetes Type I / Type II **(circle one)**		Stress (Leakage when cough/sneeze)	
Drug or Alcohol Abuse		Urgency (Frequent urination)	
Dry Eyes		Other:	
Endometriosis			

PLEASE LIST ANY SURGERIES, PROCEDURES OR HOSPITALIZATIONS YOU HAVE HAD

Surgery	Date	Hospitalization	Date
		Procedures (i.e. colonoscopy / endoscopy)	**Date**

Any ANESTHESIA problems in the past? N / Y **Explain: _____**

Any Family problems with Anesthesia? N / Y **Explain: _____**

MEDICAL HISTORY CONTINUED

Primary Care Physician: _____ Phone # _____
Name

Current weight: _____ Ideal weight: _____ Height: _____

Do you exercise regularly? N / Y If so, how? _____

Have you ever smoked? N / Y If yes, do you still smoke? N / Y How many packs per day? _____

At what age did you start? _____ At what age did you stop? _____

Do you drink alcohol? N / Y How many drinks per day? _____ Per week? _____

Do you have wear dentures/retainer? Y / N Do you have caps or a bridge? Y / N

WHEN DID YOU LAST HAVE THE FOLLOWING?

Exam / Testing	Date	Where
Physical Exam		
Blood Work		
EKG		
Chest X-Ray		
Menstrual period (if applicable)		
Mammogram		
Gynecological Exam		
Other:		

DESCRIBE YOUR HISTORY OF

Sun Exposure:	
Skin Cancer:	
Acne:	
Other skin Problems:	
Have you ever used Accutane for your skin: Y/ N	When?

CHECK IF YOUR BLOOD RELATIVES HAVE HAD

Illness	Yes	Who (Blood Relative)
Blood Clots legs / lungs		
Breast Cancer		
Cancer: Type _____		
Clotting disorder		
Diabetes		
Heart Trouble		
High Blood Pressure		

MR# _____

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING

Drug Name	Dosage	Frequency	Reason
List **hormone therapy** and **birth control medication**			
List the Herbal, Vitamins and Over the Counter drugs you use			

ALLERGIES

DO YOU HAVE ANY KNOWN ALLERGIES TO MEDICATIONS? N / Y
If Yes, please check the list below

Allergy	Yes	Reaction	Allergy	Yes	Reaction
Adhesive Tape			Demerol		
Barbiturates			Morphine		
Cephalosporins (Keflex)			NSAIDS (Advil, Aleve, etc…)		
Codeine			Penicillins		
Erythromycin			Sulfa		
Iodine			Tetracyclines		
Lidocaine			Other:		
FOOD ALLERGIES SUCH AS: (Circle all that apply) Eggs Soy Nuts Shellfish Other:					
DO YOU HAVE A LATEX ALLERGY? Y / N If yes, explain:					

BY SIGNING THIS FORM, I ATTEST THAT THE ABOVE MEDICAL INFORMATION IS ACCURATE, AND I HAVE DISCLOSED ALL INFORMATION HONESTLY

Print Name: _____ Date: _____

Signature: _____

Physician Comments: