CARMEL VALLEY
FACIAL PLASTIC SURGERY

CONSULTATION AND MEDICAL QUESTIONNAIRE, PART I

DEMOGRAPHIC INFORMATION

Today's Date:

Name:

Date of Birth: Age:

Email:

Social Security #:

Home Address:

City State Zip

Home Phone #:

Cell Phone #:

Work Phone #:

☐ Single ☐ Married ☐ Divorced

Spouse Name:

Spouse Phone #:

Emergency Contact:

Emergency Contact #:

Occupation:

Employer:

Add Insurance Info: ☐ HMO ☐ PPO

_____

_____

CVFPS may contact you by the following methods:
Phone, Text, Email, Mail.

If you have any objections please let us know.

For text messaging please provide wireless carrier _____

HOW DID YOU HEAR ABOUT DR. KARAM?

(PLEASE CHECK ALL THAT APPLY)

☐ Friend ☐ Patient ☐ Family Member ☐ Physician ☐ Spa/Esthetician

If so, Name: _____

May we thank them? ☐ Yes ☐ No

☐ Realself.com ☐ Health Grades ☐ Make me Heal ☐ I.enhance

☐ Yelp ☐ Google / Yahoo! ☐ Paper / Ad

Other (Specify): _____

WHAT BOTHERS YOU?

EYES

☐ DROOPY EYELIDS
☐ PUFFY LOWER EYELIDS
☐ SAGGING LOWER LIDS
☐ DARK CIRCLES/ UNDER EYE HOLLOWS
☐ EYE BROW SAGGING
☐ LASHES

FACIAL FULLNESS

☐ LOSING VOLUME/FULLNESS
☐ FACE APPEARS "TIRED" OR "LESS FRESH"

LOWER FACE

☐ SAGGING JAW LINE
☐ SAGGY NECK
☐ NECK FALLING (TURKEY NECK)
☐ FACIAL FOLDS
☐ THIN LIPS

NOSE

☐ DISSATISFIED WITH SHAPE
☐ DIFFICULTY BREATHING
☐ UNHAPPY WITH A PREVIOUS SURGERY

SKIN

☐ FINE LINES AND WRINKLES
☐ BLOTCHY APPEARANCE/ SUN SPOTS

OTHER

☐ HANDS APPEAR THIN AND AGED

WHEN DO YOU WISH TO HAVE YOUR PROCEDURE?

☐ ASAP ☐ Within 1 month ☐ 1-3 months ☐ Not Sure

AUTHORIZATION / ASSIGNMENT: I understand that I am financially responsible for all charges, whether or not covered by my insurance company. Furthermore, I permit payment directly to AMIR M. KARAM, MD, for any benefits due or services rendered.

MEDICAL RECORDS: Authorization is hereby granted for release of any information required to process this claim. A copy of this authorization is as valid as the original. Authorization is hereby granted for release of pertinent information (this may include photographs, operative notes, clinic and consultation notes) to a hospital / another physician's office for appropriate continuum of care treatment as required.

PRIVACY POLICY: I acknowledge I have received / have been offered a copy of AMIR M. KARAM, MD, notice of privacy practices.

Signature: _____

Date: _____

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San Diego, CA 92130

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fax (858) 259-3221

www.DRKARAM.com

CARMEL VALLEY
FACIAL PLASTIC SURGERY

CONSULTATION AND MEDICAL QUESTIONNAIRE, PART II

MEDICAL HISTORY

Height: Weight:

Family Physician:

Address / Phone Number: /

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

(PLEASE CHECK ALL THAT APPLY)

Headaches	Strokes
Seizures	Fainting Spells
Heart Disease	High Blood Pressure
Chest Pain	Shortness of Breath
Lung Disease	Thyroid Disease
Liver Disease / Hepatitis	Ulcers
Anemia	Bleeding Problems
HIV	Blood Clots

Family / Personal history of problems with Anesthesia Yes No

Do you have any other medical problems / conditions? (Please list below)

Have you ever had surgery before? (Please list below)

Type	Date

List any medications you take on a regular basis (Including appetite suppressants, vitamins, herbal supplements, or any homeopathic medication)

Name	Dosage

Do you have any allergies to medications?

Name	Reaction

Latex Allergy ☐ Yes ☐ No

SOCIAL HABITS

Cigarette Smoking: ☐ Yes ☐ No # of cigarettes / day: ___

Alcohol Use: ☐ Yes ☐ No # drinks / week: ___

Drug Use: ☐ Yes ☐ No

DOCTOR'S NOTES

FACIAL REJUVENATION

- ☐ SI FACELIFT
- ☐ NECK LIFT
- ☐ SI FACE LIFT W/ EXTENDED NECK
- ☐ SUB MENTAL LIPO
- ☐ LATERAL BROW LIFT
- ☐ SI FACE LIFT AND NECK LIFT
- ☐ CHEEK / BROW LIFT

VOLUME

- ☐ FULL FACE FAT TRANSFER
- ☐ PERI ORBITAL FAT TRANSFER
- ☐ PERI ORAL FAT TRANSFER
- ☐ INFRA ORBITAL FAT TRANSFER
- ☐ FAT TRANSFER W/ (SUBSCISION)
- ☐ HAND FAT TRANSFER

EYE REJUVENATION

- ☐ UPPER BLEPHAROPLASTY
- ☐ LOWER BLEPHAROPLASTY
- ☐ SKIN PINCH
- ☐ QUAD BLEPH (UPPER, LOWER, SKIN PINCH)
- ☐ LATISSE

NOSE

- ☐ RHINOPLASTY
- ☐ SEPTOPLASTY
- ☐ RHINO/SEPTOPLASTY
- ☐ REVISION RHINOPLASTY

OTHER

- ☐ OTOPLASTY
- ☐ CHIN AUGMENTATION

NON SURGICAL

- ☐ BOTOX
- ☐ JUVEDERM ULTRA/ U+
- ☐ RESTYLANE
- ☐ SCULPTRA
- ☐ RADIESSE

SKIN

- ☐ OBAGI
- ☐ 35% TCA
- ☐ LIGHT CHEMICAL PEEL

NOTES

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