BECK AESTHETIC SURGERY 704-800-4642

Patient's Legal Name (As it appears on your Identification.)

First: ______________________________ Middle: ______________________ Last: _____________________________

Preferred Name / Pronouns (If prefer not to disclose, put N/A): _______________________________________

Address:

City: ___________________________ State: __________________________ Zip: ________________

Contact:

Phone: _____________________________________ E-mail: ____

Age: ___________ Birthdate: ______________________

Marital Status: Single | Married

Emergency Contact: ______________________________ Relationship to You: _____________ Phone: ______________

Preferred Pharmacy: ____________________________________ Phone: ________________________

How did you hear about our office?

(Mark all that apply)

☐ Instagram ☐ Facebook ☐ Google ☐ Realself ☐ Friend/Relative ☐ Doctor ☐ Email Blast

If you were referred by a specific person, please list their name: ____________________________________

Areas of Interest for Your Consultation:

(Mark all that apply)

FACE:

☐ Face Lift and/or Neck Lift
☐ Brow Lift and/or Hair Line Lowering/Advancement
☐ Eyelid Lift
☐ Fat Grafting to the Face
☐ Chin Augmentation (Implant)
☐ Liposuction to the Face and/or Neck
☐ Rhinoplasty
☐ Facial Feminization
☐ Facial Masculinization

CHEST:

☐ Breast Lift
☐ Breast Reduction
☐ Breast Augmentation (Implants)
☐ Implant Removal or Replacement
☐ Gynecomastia
☐ Top Surgery

BODY:

☐ Tummy Tuck
☐ Liposuction
☐ Fat Grafting to the Buttocks (BBL)
☐ Mommy Makeover
☐ Arm Lift
☐ Thigh Lift
☐ Body Masculinization
☐ Body Feminization

MED SPA:

☐ Hair Restoration
☐ Wrinkle Injections (Botox & Dysport)
☐ Filler Injections (Restylane & Juvederm)
☐ Skin Care Products
☐ Microneedling
☐ Clinical Facials and/or Chemical Peels
☐ Scar Camouflage Micropigmentation
☐ Laser Hair Reduction
☐ Laser Skin Resurfacing
☐ IPL

Tell us more about the reason for your visit:

____

____

List ALL previous surgeries (including cosmetic procedures) with the year performed:

Health Problems Past & Present: (Mark all that apply)

☐ Diabetes
☐ High Blood Pressure
☐ Heart Problems (angina, valve disease, heart failure, or a previous heart attack)
☐ Lung/Breathing Problems (asthma and chronic obstructive pulmonary disease, or COPD)
☐ Bleeding/Clotting Problems
☐ Anemia
☐ Cancer
☐ Kidney Problems
☐ Stroke
☐ Seizures (or any other neurological disorders)
☐ OCD/Anxiety/Depression
☐ Obstructive Sleep Apnea
☐ Other- ____

If marked above, explain length and severity of condition: ____

Do you have any allergies to anesthesia or a history of adverse reactions to anesthesia? _________________________

Do you have any known allergies? (Drugs, Latex, Shellfish, etc.) ____

Medications:

Include all Prescription, Hormone Topicals, Over-The-Counter, Vitamins and Herbal supplements taken regularly.

____

Do you vape, smoke cigarettes or use other nicotine products?

☐ Yes ☐ No

Do you use marijuana?

☐ Yes ☐ No

Alcoholic Drinks Per Week: ____________

Height & Weight: ___’___” / _____lbs

Have you ever lost more than 50lbs? If so, how much and when? ____

Do you have Children?

☐ Yes ☐ No

I certify that the above facts are true to the best of my knowledge and belief:

Patient Signature ____ Date: ___________________________

Reviewer Signature ____ Date: ___________________________