BAY AREA AESTHETIC SURGERY

(650) 570-6066

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name ____

First Middle Last

Purpose of Visit: ____

____

Previous Surgeries with Dates: *(Including cosmetic procedures)*

____

____

____

Health Problems Past & Present: *(mark all that apply)*

❒ Diabetes ❒ High Blood Pressure ❒ Heart Problems

❒ Easy Bruising ❒ Lung/Breathing Problems ❒ Bleeding/Clotting Problems

❒ Cancer ❒ Psychiatric / Depression

❒ Other: ____

Please explain all positive responses: ____

____

Do you smoke? ❒ No ❒ Yes, How many packs a day? ________ **Alcoholic Drinks Per Week:** ________________

Height __________________ **Weight** _________________ **Ages of Children** ______________________________

Medications: *(include all Prescriptive, Over-The-Counter, Vitamins and Herbal medications taken regularly)*

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____

Drug or Latex Allergies: *(please indicate if none)*

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____

Primary Physician ______________________________ Phone ____________________

First and Last Name

Date of Last Physical: __________________________

Female Patients: *(Please complete)* I am pregnant ❒ No ❒ Yes I am breastfeeding ❒ No ❒ Yes

Are you currently seeing an esthetican? ❒ No ❒ Yes Salon Name: ____________Esthetician: ______________

The above information is accurate and complete to the best of my knowledge.

Signature ____ **Date** ____________________