ST

MEDICAL HISTORY

Today's date | Consult date

Name | Date of birth

Age | Sex ◯ M ◯ F | Marital status ◯ Single ◯ Married ◯ Divorced ◯ Widow ◯ Separated

Address

City | State | Zip Code

Phone | Home | Work | Mobile

Which is preferred to leave a private message?

Email

Occupation | Employer

Emergency contact | Name | Relation

Email | Best number(s)

How were you referred to Dr. Teitelbaum? Please offer details, e.g. name of person, word-of-mouth, search engine, website, review site, magazine, etc.

What procedure(s) are you considering?

Why are you looking into this now?

Have you already decided to have surgery or are you gathering information?

Have you consulted with another plastic surgeon? ◯ Yes ◯ No

Are you planning to consult with another plastic surgeon? ◯ Yes ◯ No

What is your best time frame for surgery?

Which of the following are of particular importance in your decision to have plastic surgery?

- ◯ Looking overdone/fake/obvious/unnatural
- ◯ Looking underdone/wasn't worth it/not enough change
- ◯ Pain
- ◯ Time off work/child care
- ◯ Complications
- ◯ Scars
- ◯ Operating room accreditation
- ◯ Surgeon expertise/board certification
- ◯ Anesthesia
- ◯ Safety
- ◯ Availability of doctor and nurse after surgery
- ◯ Budget
- ◯ Support of family/friends
- ◯ Recovery time
- ◯ Other

Personal physician | Date of last exam

Height | Weight | Desired weight

Do you smoke? ◯ Yes ◯ No | If so, how much?

Do you vape? ◯ Yes ◯ No | If so, how much?

Do you drink? ◯ Yes ◯ No | If so, how much?

List food and drug allergies and type of reaction

In the past six months have you taken

- ◯ Accutane
- ◯ Aspirin
- ◯ Cocaine
- ◯ Birth control pills
- ◯ Growth hormone
- ◯ Female hormone replacement
- ◯ Oral prednisone/cortisone
- ◯ Recreational drugs

List all other medications you have taken in the past 6 months (including herbs, vitamins, and supplements)

List previous plastic surgery procedures, surgeons and dates

List other operations and dates

List other hospitalizations or medical problems for which you have been treated

Do you have/have you been treated for

- ◯ Alcoholism
- ◯ Anxiety
- ◯ Arthritis
- ◯ Asthma
- ◯ Bipolar disorder
- ◯ Blood clots
- ◯ Blood clots in family
- ◯ Cancer
- ◯ Depression
- ◯ Diabetes
- ◯ Drug addiction
- ◯ Dry eyes
- ◯ Eating disorder
- ◯ Excessive/abnormal bleeding
- ◯ Heart disease
- ◯ Hepatitis
- ◯ High blood pressure
- ◯ HIV/AIDS
- ◯ Keloids or bad scars
- ◯ MRSA exposure
- ◯ MRSA infection
- ◯ Nausea/vomiting with anesthesia
- ◯ OCD
- ◯ Psoriasis
- ◯ Psychiatric care
- ◯ Seizures
- ◯ Thyroid problems
- ◯ Ulcers

Have you or your relatives had an unusual reaction to anesthesia such as weakness, breathing problems, or fevers? ◯ Yes ◯ No ◯ N/A

Have you or your relatives had unexplained blood clot? ◯ Yes ◯ No ◯ N/A