Name: (Last) _____(First) _____ (MI) ___
Address:_____
City: _____ State: _____ Zip Code: _____

Cell Phone: _____ **Home Phone**: _____

Date of Birth: _____

Email Address: _____

Marital status: □ Single □ Married □ Divorced □ Widowed

Gender: □ Female □ Male □ Transgender □ Female to Male □ Male to Female

Preferred Pronoun: □ She □ He □ They/Them

Primary Care Physician : _____

How did you hear about us?

_____

EMERGENCY CONTACT INFORMATION: Name: _____
Relationship: _____ Phone Number: _____

REASON FOR COSMETIC CONSULT: Please indicate the nature of your visit and/or the procedure(s) you would like to discuss:

□ Mommy Makeover □ Breast Augmentation □ Liposuction □ Body Lift □ Facelift □ Eyelid lift □ Rhinoplasty
□ Tummy Tuck □ Breast Lift □ Breast Reduction □ Gynecomastia □ Arm Lift □ Botox/Fillers □ Laser Treatment
□ Chemical Peels □ Hair Removal □ Laser Tattoo Removal □ Microneedling
Other (please explain) _____

HEALTH AND MEDICAL INFORMATION: Height: _____ Weight: _____ Age : _____

Habits: Have you ever smoked? □ yes □ no If yes, ____ packs/day for ___ Still smoke? □ yes □ no

Date you quit: _____ **Alcohol**: _____ **Aspirin**: _____

ALLERGIES: Please list all allergies to medications, tape, latex, iodine, etc. and the reaction

Penicillin Allergy? ___

Allergy/ Reaction	Allergy/Reaction

MEDICATIONS: Please list all the medications you are currently taking, prescription and nonprescription, supplements, vitamins, diet pills and those medications you may not take every day.

Medication/ Dose	Medication/Dose

HEALTH AND MEDICAL INFORMATION

Surgery History:_____

Bleeding Problems/ Blood Clots:_____

Fractures/ Trauma :_____

Present Illness/ Significant Illnesses:

_____

Do you, or have you experienced any problems in the following areas:

Head & Neck:_____

Ear, Nose or Throat :_____

Heart & Lungs:_____

Intestinal:_____

Urinary:_____

Skin:_____

Cold Sores:_____

Have you experienced:

A prolonged cough for more than 3 weeks? ___ Night sweats or excessive chills? ___