Montefiore
Inspired Medicine

Aesthetic Surgery
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Aesthetic Consultation Form

Patient Registration

Name: _____

Telephone: Day (____) _____ Evening (____) _____ Cell (____) _____

Date of Birth: _____ Email: _____

What do you hope to achieve with your visit today? _____

_____

_____

How did you hear about us?_____ Referred By:_____

Doctor Patient Friend (Circle one)

Please circle which of the following you wish to discuss with the doctor?

Face	Upper Eyelids	Neck	Breasts	Spider Veins
Ears	Lower Eyelids	Chin	Abdomen	Other_____
Wrinkles	Body	Nose	Varicose Veins	

Patient History

The following profile is to correctly evaluate your individual needs both here, as well as home maintenance. This information is completely confidential and to be used for this analysis only.

1. **List *ALL* cosmetic procedures and surgeries done by a cosmetic surgeon. Please include name of surgeon and the year.**

2. **Were you satisfied with the results of the previous plastic surgery?** YES NO SOMEWHAT

3. **Please list any *OTHER* past surgeries and the year performed (i.e. C-Section, Tonsils)**

4. **Are you allergic to any of the following:**

__ Penicillin ___Tetracycline ___Iodine ___Keflex ___Bacitracin ___ Tapes ____Latex

__ Sulfites ___Soybean ___Eggs ___Erythromycin ___Sulfa drugs Other: _____

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5. **Have you had any of these problems in the past?**

•High Blood Pressure:	Yes	No	•Heart Problems:	Yes	No
•Thyroid:	Yes	No	•Bleeding Problems:	Yes	No
•Diabetes:	Yes	No	•Blood clots in legs:	Yes	No
•Epilepsy:	Yes	No	•Poor scarring/Keloids:	Yes	No
•Cancer:	Yes	No	•Herpes/ Cold Sores:	Yes	No

Other: Yes No Describe:_____

6. **List current medications:**

Medication Dosage Frequency Purpose

_____
_____
_____
_____

7. **Have you had Botox or Fillers previously done?** Yes or No

If Yes, How many times? _____ Date of last injection? _____

Circle areas of injection: Forehead Neck Lips Eyes Other_____

8. **Do you smoke?** Yes or No **How much? _____ When did you quit? _____**

Have you ever smoked? Yes or No **If Yes, for how long? _____**

9. **Do you drink alcohol?** Yes or No **How often?** Daily, Occasional, or Social

10. **Do you currently use or have you used in the past any of the following?**

Marijuana Cocaine Heroin LSD Methadone Other_____

11. **Are you pregnant?** Yes or No **Date of last menstrual period? _____**

12. **For patients contemplating eyelid surgery, please list your Ophthalmologist:**

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13. **Are you currently under the care of a psychiatrist or psychologist?** Yes or No

14. **List any *FAMILY HISTORY* of significant medical problems that you may think may be important (i.e. heart disease, cancer, diabetes)**

I confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to my participation in aesthetic procedures. I will inform Montefiore Aesthetics to any future changes in this information.

_____	_____	_____
Print Name	Signature	Date