MR#:

CG Cosmetic Surgery
305 - 446 7277

Please make every effort to fill out the information fully and accurately.
Your responses are held strictly confidential and are not shared.

Today's Date:

Name _____
First Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail _____

Preferred Method(s) of Contact: ❒ Home Phone ❒ Cell Phone ❒ Work Phone ❒ Email

Please do not contact me by: _____

Age _____ Birthdate _____ SS# _____ Gender ❒ Female ❒ Male

Height _____ Weight _____ Number of Children _____

Highest Level of Education ❒ High School ❒ Some College ❒ College ❒ Masters ❒ Doctorate

Marital Status: ❒ Married: Spouse's Name: _____ ❒ Single ❒ Separated/Divorced ❒ Widowed

If child, who may authorize treatment? Relationship:

Contact : First Name _____ Last Name _____ Relationship _____

Home Phone Cell Phone Other Phone

Employer _____ Occupation _____

Address _____
Street & Suite # City State Zip

Spouse Employer _____ Occupation _____

Work Phone _____

Address _____
Street & Suite # City State Zip

Please indicate your area(s) of interest:

NON SURGICAL	FACE	BREAST	BODY
❒ Botox ❒ Wrinkles ❒ Skin Filler ❒ Lip Enhancement ❒ Smile or Nasolabial Lines ❒ Skin Care / Enhancement ❒ Obagi Blue Peel ❒ Other	❒ Eyes - Blepharoplasty ❒ Ears - Otoplasty ❒ Nose - Rhinoplasty ❒ Facial Implant - Cheeks ❒ Facial Implant - Chin ❒ Forehead/Brow Lift ❒ Facial Sculpting ❒ Necklift ❒ Facelift ❒ Other	❒ Breast Enlargement ❒ Breast Implant Deflation ❒ Breast Implant Change ❒ Breast Lift ❒ Breast Reduction ❒ Male Breast Reduction ❒ Other	❒ Liposuction ❒ Tummy Tuck ❒ Labiaplasty ❒ Arm Reduction ❒ Brazillian Butt Lift ❒ Other

Please use this space to provide any other information you feel may be helpful to your consultation:

Procedure		Doctor		How long ago?	
Procedure		Doctor		How long ago?	
Procedure		Doctor		How long ago?	
Procedure		Doctor		How long ago?	

How did you hear about us? **Patient** (Mark all that apply)

❒		❒ Radio:	
❒ Email Promotion:		❒ Business:	
❒ Website:		❒ Phonebook:	
❒Magazine:		❒ Newspaper	
❒ Event:		❒ TV Show:	
❒ General Reputation		❒ Other:	
❒ Friend/Relative:		❒ Doctor:	

Medical History

Your medical history is an extremely important part of your consultation. It helps alert us to any potential conditions that may interefere with your surgery. Please take your time and fill this our as completely and accurately as possible. If you need any help or have questions, our staff will be happy to assist you.

List **All Prescription and *Non Prescription*** medications you are taking:

List any **Medical Conditions** you have or had:

List any **Surgery** you have had (including Cosmetic Surgery) **with dates**:

List any serious **Major Illness / Injury** you have had in the past:

List any **Diet Pills** you take (May cause problems with anesthesia):

List any **Drug Allergies**:

List any **Contact Allergies** (latex or other products):

Describe any difficulties you have had with **anesthesia**:

Breast Cancer Family History: Do you have:

❒ 2 or more relatives with breast cancer
❒ 2 or more relatives with ovarian cancer
❒ A relative with both breast and ovarian cancer
❒ A male relative with breast cancer
❒ A relative with got breast cancer before age 50
❒ An Ashkenazi Jewish heritage relative with breast or ovarian cancer

Do you Smoke? ❒ No ❒ Yes: What? _____ How much per week? _____ How many years? _____

Do you drink Alcohol? ❒ No ❒ Occasionally ❒ 1-2 drinks daily ❒ 3 or more drinks daily

Do use any Recreational Drugs?

❒ No ❒ Yes: What? _____ Times a Week? _____ How Many Years? _____

Are you or have you ever had an addiction to narcotics or recreational drugs?

❒ No ❒ Yes: What? _____ Duration of use? _____ Date of last use: _____

How do you rate your general health? ❒ Poor ❒ Fair ❒ Good ❒ Excellent

Are you under a doctor's care? ❒ No ❒ Yes: Whom? _____

Review the list below and check anything applicable. If you check any box, use the space below to explain further if needed.

❒ Chronic Skin condition	❒ Coughing up blood	❒ Blood in Urine or trouble urinating
❒ Severe drynes of the eyes	❒ Lung disease	❒ Bleeding disorders (you or family)
❒ Glaucoma or blurry vision	❒ Chronic hoarseness	❒ Blood clots (you or family)
❒ Wear Glasses/Contacts	❒ Heart Attack	❒ Menstrual disorder
❒ Drainage from ears	❒ Heart disease	❒ Easy bruising
❒ Difficulty Hearing	❒ Racing heart rate without cause	❒ Anemia
❒ Ringing in Ears	❒ High Blood Pressure	❒ Altered Thryoid hormone levels
❒ Recurrent severe dizziness	❒ Chest pain	❒ Diabetes
❒ Nasal Injury	❒ Swollen legs and ankles	❒ Low blood sugar
❒ Frequent Nose bleeds	❒ Stroke	❒ Always thirsty or urinating
❒ Difficulty Breathing from Nose	❒ Cancer	❒ Sensation changes
❒ Difficulty Smellling	❒ Abnormal lump	❒ Treated/Tested positive for Tuberculosis
❒ Chronic Sinus Infections	❒ Enlarged lymph node	❒ Treated/Tested positive for HIV
❒ Frequent Nasal Allergies	❒ Unexplained weight loss	❒ Treated/Tested positive for AIDS
❒ Chronic sinus/nasal blockage	❒ Problems with bones or joints	❒ Treated/Tested positive for Hepatitis
❒ Difficulty with Taste	❒ Arthritis	❒ Hospitalized for mental illness
❒ Recurrent fever blisters	❒ Joint Disease	❒ Emotional/Psychological concern
❒ Severe headaches	❒ Acid Reflux	❒ Under Psychiatric care
❒ Head Injury	❒ Stomach ulcers	❒ Alcoholism / Drug Addictions
❒ Paralysis (Face or Body)	❒ Chronic Abdominal problems	❒ Complications after surgery
❒ Shortnes of breath	❒ Yellow Jaundice or Hepatitis	❒ Bad/ unsatisfactory surgical outcome
❒ Sleep on pillows to help breathing	❒ Blood in Bowel movements / Stool	❒ **NONE OF THE ABOVE**
❒ Asthma or emphysema	❒ Kidney or bladder problems	❒ Other: _____

Please explain:

I have read this form entirely and have completed it fully and accurately to the best of my knowledge.

Patient Signature **Date**

Date Reviewed