

ADVANCED COSMETIC SURGERY CENTER OF WALNUT CREEK

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INFORMATION FOR CASE HISTORY FILE

Please complete all items. Please print

Date: _____ BP _____

Name: _____ Age: _____ Date of Birth: _____

Preferred method of contact (circle all that apply): Phone- Home Work Cell Email Mail

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Email: _____

Social Security #: _____ Driver License #: _____

Occupation: _____ Employer: _____

Business Address: _____ Business Phone: _____

Name of Spouse: _____ Spouses Occupation: _____

Spouses Employer: _____ Address: _____ Phone: _____

Family Doctor or Internist: _____ Address & Phone: _____

Has this office ever seen or treated any member of your family? No Yes

If yes, whom? _____

Nearest Relative and address: _____ Phone: _____

Referral Information How did you find us?

Friend or acquaintance? _____ Relative? _____

Your healthcare professional? _____ Newspaper ad? _____

Magazine ad? _____ Television special? _____

Yellow page ad? _____

Internet? (circle each that apply)

Jervismd.com

Plasticsurgery.org

Implantinfo.com

Surgery.org

Implantforum.com

lenhance.com

Plasticsurgery.com

Cosmeticsurgery.com

Breastaugmentation.com

Topsurgeononline.com

Faceforum.com

Yedda.com

Breastimplants411.com

Liposite.com

Other: _____

Present problem/concern

Specific concern for which you are seeking plastic surgery: _____

Have you consulted any other doctors, including plastic surgeons about this? No Yes

If yes, please list their names: _____

Injuries

Type	Year	Hospital	Doctor	After Effects

Family History

Age	State of Health	Has any relative had:	
Mother _____	_____	Tuberculosis	Yes No
Father _____	_____	Cancer	Yes No
Siblings _____	_____	Epilepsy	Yes No
Children _____	_____	Heart Disease	Yes No
_____	_____	High Blood Pressure	Yes No
_____	_____	Lung Disease	Yes No
_____	_____	Kidney Disease	Yes No
_____	_____	Blood or bleeding disorders	Yes No
_____	_____	Asthma	Yes No
_____	_____	Mental Disease	Yes No

Medications, Drugs

What is your approximate daily consumption of the following:

Coffee or tea _____ Alcohol _____ Tobacco _____

Other intoxicating or mind altering drugs (please specify) _____

Does anyone else in your household smoke? Yes No

Name of your Pharmacy _____ Phone # _____

Please list ALL your medications and their medications and their dosages. Including: birth control pills, diuretics (water pills), blood pressure, heart medications, tranquilizers, hormones, blood thinners, nose drops/sprays, inhaler medications, rub-on medications (liniments), aspirin, bufferin, motrin, advil, or other pain/arthritis medication, diet pills, herbal products including ginko biloba, homeopathic products, vitamins and any other over the counter medications. Both prescribed by physician and non-prescribed.

_____	_____
_____	_____
_____	_____
_____	_____

Pertinent preoperative information (Circle correct answer)

Are you allergic to any medications? **No** **Yes** (please list) _____

Have you ever had accutane pills of acne? No Yes

Have you ever reacted badly to being put to sleep for surgery? No Yes

Has any member of your family ever reacted badly to being put to sleep for surgery? No Yes

Have you ever required unusually large amounts of local anesthetic for medical or dental procedures? No Yes

Have you ever had a bad reaction to a local anesthetic (Novocaine, etc?) No Yes

Are you allergic to adhesive tape? No Yes

Are you allergic to suture material such as catgut? No Yes

Do you have high blood pressure? No Yes

Have you ever had scarlet fever or rheumatic fever? No Yes

Do you bleed unusually easily (from cuts, surgery, tooth extractions?) No Yes

Do you bruise easily? No Yes

Are you a slow or poor healer? No Yes

Do you form large scars or keloids? No Yes

Do you have any skin disease, hives, eczema or rash? No Yes

Do you have frequent infections or boils? No Yes

Have you taken steroid medications, cortisone or ACTH? No Yes

Do you have shortness of breath with walking? No Yes

Do you have, or have you had any back trouble? No Yes

Does your religion prohibit blood transfusions? No Yes

Do you have, or have you had any significant emotional problems? No Yes

Have you ever had, or been advised to seek psychiatric care? No Yes

Have you had any illness or disorders of the following? (Circle if yes)

Brain (incl.strokes, epilepsy)	Face (paralysis)	Heart or Blood vessels	Blood	Arms or Legs	Nervous System (incl paralysis, numbness, seizures)
Nose, sinuses, throat	Stomach	Intestines	Urinary System	Bones or Joints	Eyes & Ears
Breasts	Intestines	Reproductive system	Endocrine System or Diabetes	Liver	Lungs

If circled, please explain: _____

Signature _____

Parent signature _____

(For patients under the age of 18)