BASILE PLASTIC SURGERY

CONSULTATION AND MEDICAL QUESTIONNAIRE

Name_____ Date of Birth _____Age_____ Today's Date_____

Address: Home_____
Street City State Zip

Address: Business/Northern_____
Street City State Zip

Home Phone_____ Business or Northern Phone_____

May we call you at these numbers? YES NO May we leave a message with person who answers or on machine? YES NO

Social Security Number_____--_____--_____Marital Status S M D W Sep Ages of Children_____

E-mail address: _____@_____

How were you referred to us?_____

Names of family members who are patients_____

Which areas of the body are you interested to address?

- ❑ Face
- ❑ Eyes
- ❑ Nose
- ❑ Lips
- ❑ Neck
- ❑ Breasts
- ❑ Chest
- ❑ Abdomen
- ❑ Arms
- ❑ Flanks
- ❑ Buttocks
- ❑ Hips
- ❑ Thigh/Legs
- ❑ Back
- ❑ Other_____

What **specifically** do you wish to have corrected?_____

_____

When did you begin to consider surgical correction?_____

Is having surgery your idea or is it someone else's idea?_____

Why have you decided to have it done at this point in time?_____

Have you consulted with any other doctor about this? When?_____

Have you discussed this surgery with your family? YES NO Are they agreeable? YES NO

Do you understand that the objective of any cosmetic operation is improvement in appearance, not perfection? YES NO

Are you aware that the results of the operation might not fully meet your expectation? YES NO

Have you had any previous cosmetic surgery? YES NO If so, when and what was done? _____

_____

Who performed the surgery? _____ Where was it performed? _____

Were you satisfied with the results? _____If not, why? _____

Have you had **any** other surgery, or an **injury**, to the body area in question? _____

When? _____ Describe as best you can_____

Has anyone in your family or a close friend had cosmetic or reconstructive surgery? _____

What was done? _____ By whom? _____

PLEASE COMPLETE MEDICAL HISTORY ON OTHER SIDE

BASILE PLASTIC SURGERY

MEDICAL HISTORY

Do you currently take any Drugs or Medications?
If so, please list: _____ _____
_____ _____ _____
_____ _____ _____

Do you take Aspirin, Motrin, Advil, Aleve, or any aspirin containing medications? Yes / No
If so, most recent dose ?_____

Are you Allergic to any medications, creams, or tape?
Yes / No List them please _____
_____ _____ _____
_____ _____ _____

Who is your primary doctor? _____
Address or Ph #? _____
Last Physical Examination?_____
Was everything ok? Yes / No

Do you have/Have you had? (circle if yes)

Heart Trouble	High Blood Pressure	Diabetes
Excessive Bruising	Infections	Thyroid issues
Psychiatric diagnoses	Excessive scarring	Seizures
Dizzy spells	Severe headaches	Anemia
Blood clots	Pulmonary emboli	Stomach Ulcers
Chest Pains	Asthma	Tuberculosis

History of Bleeding?: From the nose? In the Urine?
(circle if yes) From the Rectum? Vomiting blood?
Coughing blood? Other?

Have you previously had any **Surgery**?
List please:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Yes / No Have you ever received local anesthesia? (Lidocaine or Novocaine from doctor or dentist?)

Yes / No Did you have any negative reaction to local anesthesia?

Yes / No Are you considered a healthy person?

Yes / No Do you take vitamins regularly?

Yes / No Where you ever told you have AIDS?

Yes / No Do you smoke cigarettes at all?

Yes / No Do you vape or chew tobacco?

Yes / No Do you use a nicotine patch or chew nicotine gum?

Yes / No Have you ever considered consulting a psychiatrist?

Yes / No Do you often get depressed?

Yes / No Do strange places make you afraid?

Yes / No Are you considered a nervous person?

Yes / No Have you ever had a "nervous breakdown"?

Yes / No Do you use marijuana?

Yes / No Are you currently under the care of a psychiatrist?

Yes / No Do you usually have 2 or more alcoholic drinks a day?

Yes / No Do you drink more than 4 cups of coffee a day?

Have you ever had a fever blister or cold sore? Yes/ No

Has any part of your body ever been paralyzed or numb?
Yes/ No
Explain _____

Do you have any medical problems that have not been covered? _____

Is there any reason you should not have an operation at the present time? _____

Thank you. - *Andrea Basile, MD*