

Personal Information

Name		DOB		Date	
Preferred name		Social Security #			
Marital status	Single	Married	Divorced	Widow(er)	
Does your spouse or significant other know about your interest in this procedure?				Y	N
If yes, do they agree with your decision for surgery?				Y	N
Mailing address					
	City		State		
Phone (home)		Cell		Office	
Occupation		Employer			

Emergency contact

Name		Relationship			
Phone (home)		Cell		Office	

How were you first referred to Dr. Connall?

American Society of Plastic Surgeons (ASPS) website: plasticsurgery.org					
drconnall.com	If so, please check the search engine you used below:				
ask.com	dogpile	google	infospace	MSN	Yahoo!
Cosmetic Surgery Network.com					
Implantinfo.com					
Justbreastimplants.com					
Lookingyourbest.com					
Citysearch.com					
Other website					
Patient of Dr. Connall's					
Dr. Robinson & staff					
Patient of Dr. Robinson's					
Yellow pages (Quest Dex)					
Yellow pages (Verizon)					
White pages					
Other					

What can we help you with? (please check all that apply)

Breast augmentation	Brow lift	Facial implants	Tummy tuck
Breast lift	Upper eyelids	Chin implant	Liposuction
Breast augment & lift	Lower eyelids	Facial fat grafting	Lower body lift
Corrective implant surgery	Face lift	Facial resurfacing	Thigh lift
Breast implant removal	Midface lift	Facial filler (restylane, etc.)	Buttock lift
Breast reduction	Neck lift	Botox	Upper arm lift
Male breast reduction	Neck liposuction	Ear pinning	Body fat grafting

Please list some of your favorite interests, hobbies and free time activities:

--

I acknowledge my receipt of Connall Cosmetic Surgery's privacy policy (HIPAA):

Patient signature		Date	
-------------------	--	------	--

Medical History (please check yes if you presently have the condition, no if you have never had the condition, past if you had the condition in the past, but no longer have it)

Condition	Yes	No	Past	Comments
Abnormal heart beat				
Alcoholism				
Anemia				
Anesthesia problems				
Anxiety				
Arthritis				
Asthma				
Attention deficit disorder				
Autoimmune disease				
Back pain				
Bipolar disorder				
Bleeding problems				
Bronchitis				
Cancer				
Chest pain				
Clotting problems				
Deep vein thrombosis				
Depression				
Diabetes- insulin dependent				
Diabetes- non-insulin dependent				
Drug abuse				
Dry eyes				
Ear problems				
Eating disorder				
Eye problems				
Gastric reflux				
Heart disease				
Hepatitis				
Herpes cold sores				
High blood pressure				
History of heart attack				
HIV/AIDS				
Kidney disease				
Liver disease				
Lung disease				
Lupus				
Neurological disease				
Obsessive compulsive disorder				
Organ transplant				
Post traumatic stress disorder				
Premenstrual Dysphoric Disorder				
Pulmonary embolus				
Rheumatoid arthritis				
SADD (Seasonal Affective Disorder)				
Scleroderma				
Skin cancer				
Stroke				
Thyroid disease				
Ulcer disease				
Vision problems				
Others:				

Name		DOB		Date	
------	--	-----	--	------	--

Current health status

Are you now or have you recently been treated for new medical or mental health problem(s)?	yes	no
If yes, please explain:		

Surgical history (please list all surgeries and the dates they occurred)

Procedure	Date	Procedure	Date

Medications (please list all of your medications and dosages, including herbals, supplements, and vitamins)

Are you allergic to any medications?

<input type="checkbox"/>	No, I have no known allergies to medications
<input type="checkbox"/>	Yes, I am allergic to the following:

Do you smoke?

<input type="checkbox"/>	No	If you quit, when?		<input type="checkbox"/>	Yes, I smoke	Packs/day for		years
--------------------------	----	--------------------	--	--------------------------	--------------	---------------	--	-------

Do you drink alcohol?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes, I drink	Drinks per day
--------------------------	----	--------------------------	--------------	----------------

Do you use or have you used recreational drugs?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	List types:	
--------------------------	----	--------------------------	-----	-------------	--

How often do you exercise?

<input type="checkbox"/>	Never	<input type="checkbox"/>	1-3/month	<input type="checkbox"/>	1-2/week	<input type="checkbox"/>	3-4/week	<input type="checkbox"/>	5-7/week
--------------------------	-------	--------------------------	-----------	--------------------------	----------	--------------------------	----------	--------------------------	----------

Weight status

Have you had more than 10 lbs change in weight recently?				<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Amount/Reason	
Present weight		Height		Goal weight		Maximum weight/When			
Is your weight stable?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	How long have you been at present weight?			
For Office Use Only:				Body Mass Index:					

Family Medical History (Applies to immediate relatives, e.g. parents, brothers, sisters, grandparents)

Condition	No	Yes	Comments
Major reactions to anesthesia			
Bleeding disorders			
Clotting disorders			
Deep vein thrombosis			
Pulmonary embolus			
Others:			

Have you ever had any of the following medical tests?

Test	Date	Reason	Results
EKG (heart tracing)			
Heart echocardiogram			
Heart stress test			
Heart catheterization			
Chest x-ray			
CAT scan			
MRI			
Angiogram			
Other:			

Women's health questions

Family history of breast cancer?	No	Yes	Whom?
Last mammogram	Never	Normal	Abnormal
			Mammogram date
Number of pregnancies		Number of children	
Last pregnancy		More planned?	No
			Yes
Last breast feed		For how long?	If yes, when?
History of tubal ligation	No	Yes	History of hysterectomy
			No
			Yes

Medical care information

Primary physician	None	Name
Street address		
City	State	Zip
Phone		Fax
Would you like us to write your doctor about your visit with us?		

Have you consulted with other plastic surgeon(s) about this	No	Yes	If yes, please list:
Name	Date		
Name	Date		

I understand all four pages of my patient registration and medical history intake and have completed these forms to the best of my knowledge:

Patient signature		Date	
-------------------	--	------	--