Plastic Surgery Associates

22370 Bluemound Road
Milwaukee, WI 53186

NEW PATIENT INFORMATION

Today's Date_____ Marital Status_____

Name: _____ Birthdate:___/___/___ Age:_____

Address: _____ Sex: M / F

City: _____ State: _____ Zip Code: _____

Home: (___)_____ Cell: (___) _____ Work: (___) _____

EMAIL: _____

Emergency Contact: _____ Telephone: (___) _____

How did you hear about PSA? _____

Employer: _____ Occupation: _____

Please put a check mark next to the procedures which you would like to receive more information about:

Facial Therapies:
_____Botox and/or Dysport to lessen Wrinkles
_____Juvederm, Perlane, Restylane Fillers
_____Skin Care / TCA Skin Peels
_____Lip Augmentation
_____Facial Rejuvenation

Laser Treatments:
_____Hair Removal
_____Brown Spots
_____Facial Redness
_____Spider Veins/Leg Veins
_____Broken Capillaries

Please list any current Medical Conditions:

_____

_____

Please list any Medications or Herbal Supplements that you are currently taking:

_____

_____

_____ _____
Patient Signature Date

PATIENT HEALTH QUESTIONAIRE

1. Do you have **allergic reactions** to any medications?
2. Do you react abnormally to any medication or anesthesia? Yes No If so, which? _____
3. Do you have any **family history** of cancer, heart trouble, stroke, malignant hyperthermia? _____
   If so, which family member(s)? _____
4. Do you have **cocktails** regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol? _____If so, how much? _____
5. Do you **smoke**? Yes No If so, how much? _____
6. Do you have a history of **excessive bruising or bleeding** following surgery or minor trauma (including tooth extractions or mouth trauma)? Yes No
7. Have you, or <u>your blood relatives</u> required blood transfusions following previous surgery or trauma?
   Yes No If so, please specify: _____
8. Are you **pregnant**? Yes No When was your last menstrual period? ____/____/____
9. Was it normal? Yes No
10. How many pregnancies? _____ Births: _____ Breast fed? _____ How long? _____
11. Have you ever been on Cortisone or Steroid treatment? Yes No If so, when? _____
12. Please list **all present medications**, including Birth Control Pills, hormones, vitamins and over the counter medications:

    _____

    _____
13. Do you take Diuretics? Yes No If so, what? _____
14. When was your last Physical Exam? _____/_____/_____ By whom? Dr. _____
15. When was your last Eye Exam? _____/____/_____ By whom? Dr. _____
16. When was your last Electrocardiogram (EKG) and where? _____
17. When was your last Chest X-Ray and where? _____

18. Please list **all** prior Hospitalizations and Surgical Operations, including date and reason:

HOSPITALIZATIONS:

Where:	When:	Why:

SURGICAL OPERATIONS:

What:	When:	Doctor:

DRUG HISTORY: TAKEN IN LAST 6 MONTHS:

_____STEROIDS (CORTISONE, ACTH, ETC)
_____ANTIBIOTICS
_____DIABETIC MEDICATION
_____THYROID MEDICATION
_____ARTHRITIS MEDICATION
_____TRANQUILIZERS
_____NARCOTICS
_____BLOOD PRESSURE MEDICATION
_____HEART MEDICATION
_____DIET PILLS _____

Patient's Signature_____Date:_____

PATIENT HEALTH QUESTIONAIRE

Name: _____ Age: _____ Marital Status: _____ Date: ____/____/____
Height: _____ Weight _____ lbs.
General Health is? _____Have you had a cold or flu in the past month? _____
If so, which? _____When? _____ Are symptoms still present? _____
Race (ethnic) Background is: _____

HAVE YOU EVER HAD OR BEEN TOLD THAT YOU HAD ANY OF THE FOLLOWING CONDITIONS:

Heart Trouble/Congestive Heart Failure	yes	no	Glaucoma or Eye Disorder	yes	no
Heat Attack/Heart Pain	yes	no	Visual disturbances	yes	no
Endocarditis	yes	no	Error in Refraction	yes	no
Palpitation or Irregular pulse	yes	no	Other Eye Problems	yes	no
Extra Heart Beat	yes	no	Hepatitis A	yes	no
Mitral Valve Prolapse	yes	no	Hepatitis B or C	yes	no
Stroke or TIA (Transient Ischemic Attack)	yes	no	Yellow Jaundice	yes	no
Blood Disease	yes	no	Gallstones or Gallbladder Trouble	yes	no
High Blood Pressure	yes	no	Cirrhosis of the Liver	yes	no
Abnormal Electrocardiogram (EKG)	yes	no	Alcoholism	yes	no
Rheumatic Fever	yes	no	Esophageal Varices	yes	no
Dropsy or Heart Failure	yes	no	Frequent Indigestion	yes	no
Digitalis Treatment	yes	no	Ulcers	yes	no
Shortness of Breath	yes	no	Gastritis	yes	no
Chest Pain	yes	no	Colitis/Crohn's Disease	yes	no
Asthma	yes	no	Problem Constipation	yes	no
Bronchitis	yes	no	Vomiting Blood	yes	no
Tuberculosis	yes	no	Tarry / Bloody Bowel Movements	yes	no
Pneumonia	yes	no	Hemorrhoids	yes	no
Smoker's Cough	yes	no	Thyroid Disorder	yes	no
Coughing or Spitting of Blood	yes	no	Skin Disorder	yes	no
Hay Fever	yes	no	Arthritis	yes	no
Major Allergies	yes	no	Fracture of Neck or Spine	yes	no
Frequent Respiratory Infections	yes	no	Bleeding Tendency or Disorder	yes	no
Nervous Breakdown	yes	no	Abnormal Bleeding after Tooth Extraction	yes	no
Nervous Disorder	yes	no	Airway Obstruction (Nasal)	yes	no
Insomnia	yes	no	Breast Cysts, Tumors, Abscesses	yes	no
Drug Addiction/Habit	yes	no	Nipple Discharge (Abnormal Lactation)	yes	no
Self-Destructive Tendencies	yes	no	Kidney / Bladder Problems	yes	no
Psychiatric Hospitalization or Care	yes	no	Blood Transfusion	yes	no
AIDS or HIV Infection	yes	no	Blood Infection	yes	no
Herpes	yes	no	Seizures / Seizure Disorder	yes	no
Cancer	yes	no	Abnormal Reaction to Anesthetics	yes	no
			Malignant Hyperthermia	yes	no

Patient Signature_____Date___/___/___