CONSULTATION AND MEDICAL QUESTIONNAIRE

Name:_____Birthdate_____ Age_____ Today's date _____

Home Address:_____
City State Zip

Business Address:_____
City State Zip

Home Telephone:_____Business Telephone:_____Cell Telephone_____

Marital Status: **S M D SEP.** Occupation:_____E-Mail _____

Social Security Number _____ How were you referred to Dr. Sweis? _____

Person to contact in case of an emergency? _____ Relationship_____

Telephone:_____Address:_____
City State Zip

May we call you at home? _____ at work ?_____ on your cell phone?_____ on your Email? _____

IN WHICH PROCEDURE(S) ARE YOU INTERESTED? (PLEASE CIRCLE)

Nose Reshaping	Facelift	Eyelid Lift	Laser Resurfacing	Liposuction
Breast Enlargement	Breast Reduction	Breast Lift	Breast Reconstruction	Tummy Tuck
Scar Revision	Chin Surgery	Ear Revision	Botox	Collagen/Radiesse
Restylane/Juvederm	Chemical Peel	Wart Removal	Cyst Removal	Mole Removal
Skin Care	Laser Hair Reduction	Aesthera (IPL)	Other_____	

What specifically do you wish to have corrected (i.e., what don't you like about the above?)

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 any other doctors, including plastic surgeons, about this? Yes _____ No _____
Have you discussed this with your family? Yes/No Do they agree? Yes/No
Do you understand that the object of any cosmetic operation is improvement in appearance, not perfection? Yes/No
Are you aware that the result of the operation might not fully meet your expectations? Yes/No

MEDICAL HISTORY (CIRCLE APPROPRIATE RESPONSE)

General Health: Good _____ Fair _____ Poor _____

If not "Good", please explain:
_____

Height: _____Weight _____Weight loss or gain in past year _____ lb. Loss _____ Gain _____

Name of your primary physician:_____ Telephone _____
_____
Address City State Zip

How long ago was your most recent physical check-up? _____

Would you object to our contacting your physician regarding medical problems that may arise:No_____ Yes _____

Serious Illnesses (Please list):

_____

_____

_____

Previous Surgery Cosmetic and Non-cosmetic (Please list all)

Operation	Year	Anesthesia if known (Local or General)

Have you had significant complications or after effects from any of these operations? No _____ Yes _____
Have you been displeased with the results of a cosmetic surgery? No _____ Yes _____
If "Yes", please explain:

_____

_____

YES/NO Do you take aspirin or any aspirin containing medications, Vitamin E, Medicinal Herbs?
YES/NO Have you received local anesthesia (Novocain or Xylocaine) from a dentist or doctor?
YES/NO Did you have any reaction from general anesthesia, twilight anesthesia or local anesthesia?
YES/NO Have you ever reacted adversely to being put to sleep for surgery?
YES/NO Do you suffer with recurring fever blisters?
YES/NO Do your cuts bleed longer than those other people have?
YES/NO Have you had heart problems where you needed to be premedicated prior to surgery?
YES/NO Have you ever had excessive bleeding on more than one occasion or bleeding that required the attention of a doctor?
YES/NO Are you allergic to adhesive tape?
YES/NO Are you allergic to suture material such as catgut?
YES/NO Are you allergic to latex?
YES/NO Have you ever had scarlet fever or rheumatic fever?
YES/NO Do you form large scars or keloids?
YES/NO Have you taken steroid medications, cortisone, or ACTH?
If so how long? _____
YES/NO Do you have any skin disease, hives, eczema, or rash?
YES/NO Do you have, or have you had any back trouble?
YES/NO Do you have frequent infections or boils?
YES/NO Does your religion prohibit blood transfusions?
YES/NO Do you have shortness of breath with walking?
YES/NO Do you have any allergies? (If yes please list):_____

DO YOU OR ANY FAMILY MEMBERS HAVE: (CIRCLE IF YES AND INDICATE WHO)

Heart disease_____ Thyroid disease_____
High blood pressure_____ Psychiatric or nerve problems_____
Excessive bruising_____ Excessive scarring_____
Diabetes_____ Poor healing_____
History of bleeding _____ Difficulty with anesthesia _____

DO YOU PRESENTLY OR HAVE YOU EVER HAD: (PLEASE CIRCLE)

Stroke Jaundice Paralysis Cancer Asthma Numbness Arthritis Ulcers
Seizures Chest Pains Dizziness Glaucoma Skin Problems Hepatitis Heart Problems
If Circled Please Explain: _____

_____

Do you have any medical problems that have not been covered? (Please Explain): _____

_____

MEDICATIONS/ DRUGS/VITAMINS/HERBS

What is your approximate daily consumption of the following?
Coffee or Tea _____ Alcohol _____ Tobacco _____

Other Intoxicating or mind altering drugs (specify) _____
Does anyone else in your household smoke? No _____ Yes _____ How much? _____

Please list **ALL** your medications and their dosages including **BIRTH CONTROL PILLS, DIURETICS** (water pills). **BLOOD PRESSURE** OR **HEART MEDICATIONS, TRANQUILIZERS, HORMONES, BLOOD THINNERS, NOSE DROPS** and **SPRAYS, INHALERS,OINTMENTS, HERBS, OVER-THE-COUNTER MEDICATIONS,ETC.**

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

SIGNED: _____DATE: _____

REVIEWED BY: _____DATE:_____

RESPONSIBLE PARTY INFORMATION (Primary Insurance Holder)

Responsible Party _____Birthdate_____

Address _____
Street Apt # City State Zip
Telephone # __ _____Social Security # _____Group # _____ Sex _____Marital Status _____
Employer's Name _____Telephone # _____Extension_____Full or Part Time

Is there a secondary insurance company? _____ If so, please notify our office:

Insurance Company _____

We need a copy of your insurance card(s)

In order to control the cost of your billing, we request that our charges for office visits and procedures be paid at the time of service. In the event that we provide extensive non-cosmetic services for you in the hospital, we will bill your insurance company for you. We ask all of our patients to sign the following assignment statement to expedite processing of insurance claims. We welcome payment by cash, check, VISA or Master Card. However, if your check does not clear the bank, there will be a $50 service charge by our office.

I authorize my doctor to release any information necessary to determine liability of payment and to obtain reimbursement. I hereby assign medical and/ or surgical benefits including major medical benefits of my private insurance to Iliana E. Sweis, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance company. It is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my insurance. I hereby authorize the said assignee to release all necessary information to secure payment.

_____
Signature of patient/parent/authorized person Date