Welcome to Shafer Plastic Surgery

Please fill out the following information prior to your consultation

CONTACT INFORMATION

(*Date*) _____ / _____ / 2017 (*Date of Birth*) _____ / _____ / _____ (*Age*) _____

(First) _____ (Last) _____

(*Street*) _____ (*Apt*) _____

(*City*) _____ (*State*) _____ (*Zip*)_____

Can our office forward correspondences to the address provided? YES NO

(*Cell*) _____- _____ (*Home*) _____- _____

Can our office leave a voice message if needed? YES NO

(*Email*) _____@_____

EMERGENCY CONTACT

(*Name*) _____ (Relationship)_____ (*Phone*) _____- _____

PRIMARY CARE PHYSICIAN

(*Name*) _____ (*Phone*) _____- _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE

Referred by: _____

PLEASE MARK THE PROCEDURES YOU ARE INTERESTED IN DISCUSSING

SKIN / INJECTIONS

- ☐ Botox / Dysport / Xeomin
- ☐ Voluma / Juvederm / Restylane
- ☐ Sculptra / Radiesse
- ☐ Belotero
- ☐ Tattoo Removal
- ☐ Fat Grafting
- ☐ Laser / Chemical Peel
- ☐ Skincare / Acne
- ☐ Microdermabrasion
- ☐ Hydrafacial MD

BREAST / BODY

- ☐ Breast Implants
- ☐ Breast Lift / Reduction
- ☐ Liposuction/Smartlpo
- ☐ Tummy Tuck
- ☐ Body Contouring
- ☐ Brazilian Butt Lift
- ☐ Arm Lift
- ☐ Thigh Lift
- ☐ Gynecomastia
- ☐ Labiaplasty

FACE

- ☐ Facelift / Necklift
- ☐ Blepharoplasty (Eyelids)
- ☐ Neck / Chin Liposuction
- ☐ Brow Lift
- ☐ Chin / Cheek Implant
- ☐ Earlobe Repair
- ☐ Rhinoplasty (Nose)
- ☐ Otoplasty (Ears)
- ☐ Microneedling / Microchanneling
- ☐ Other

Are you interested in meeting our Aesthetician to learn about skincare treatments and products? YES NO

What is your goal for your visit today?

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Please complete your health history prior to your consultation

MEDICAL HISTORY

☐ High Blood Pressure
☐ Diabetes
☐ Emphysema / Asthma
☐ Sleep Apnea
☐ Hypothyroid
☐ Easy Bruising
☐ Bleeding Disorder

☐ Arrhythmia
☐ High Cholesterol
☐ Heart Attack / MI
☐ Bleeding Disorder
☐ Herpes Virus
☐ Rayaud's Disease
☐ Herpes Virus

☐ Personal or family history of blood clots
☐ Personal or family history of breast cancer
☐ Any other cancer:

For Female Patients

☐ Last Mammogram:
☐ # Pregnancies: _____ ☐ C-Section: **Yes** / ☐ **No**
☐ History of Miscarriage

PREVIOUS SURGERY (*Cosmetic and Non-Cosmetic, please include year*)

☐
☐
☐

Any personal or family history of adverse *reactions to anesthesia*? ☐ **Yes** / ☐ **No**
Has anyone in your family ever been diagnosed with malignant hyperthermia? ☐ **Yes** / ☐ **No**
Any personal or family history of a *bleeding disorder*? ☐ **Yes** / ☐ **No**

MEDICATIONS

Medical **ALLERGIES** (Please List):

☐ I have No Known Drug Allergies

Current Medications:

☐
☐
☐

Do you take Aspirin, Motrin, Plavix, Coumadin or any "Blood Thinners" ? ☐ **Yes** / ☐ **No**

Are you taking or have you taken Accutane? ☐ **Yes** / ☐ **No**

BOTOX & Fillers

Last Botox / Dysport Treatment:
Area(s) Treated:

Last Filler Treatment:
Area(s) Treated:

SOCIAL HISTORY

Do You Smoke? ☐**Yes**/☐**No**
Do you Drink Alcohol ☐**Yes**/☐**No**
Do you use Street Drugs? ☐**Yes**/☐**No**

PHYSICAL

Height: Weight:
Goal Weight:
Do you exercise regularly? ☐**Yes**/☐**No**

(Please do not write below this line)

ASSESSMENT/PLAN