

AESTHETIC SURGERY ASSOCIATES

Patient Information

Patient's Full Name: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail: _____ Social Security # _____

Date of Birth: _____ Age: _____ Marital Status _____

Emergency Contact: _____ Telephone: _____ Relationship to Patient: _____

Referred By: _____ Reason for Visit: _____

Family Doctor's Name and Phone Number: _____

Clinical Data Height: _____ Weight: _____ Latex Allergy: Y N Special Diet: _____

Allergies: Y N Specify: _____

Medications: (Include regular use of Aspirin) _____

Medical History

	<u>Personal</u>			<u>Family</u>	
Hepatitis	Yes	No	How long present? _____	Yes	No
High Blood Pressure	Yes	No	How long present? _____	Yes	No
Heart Disease	Yes	No	How long present? _____	Yes	No
Heart Attack	Yes	No	How long present? _____	Yes	No
Heart Murmur	Yes	No	How long present? _____	Yes	No
Diabetes	Yes	No	How long present? _____	Yes	No
Cancer	Yes	No	How long present? _____	Yes	No
Bleeding Problems	Yes	No	How long present? _____	Yes	No

Other Medical Conditions: _____

Smoking History Yes No Quantity _____

Alcohol Intake Yes No Quantity _____

Previous Surgery

<u>Operation</u>	<u>Year</u>	<u>Hospital</u>	<u>Anesthesia</u>	<u>Surgeon's Name</u>
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Significant Complication/Side Effects from Operations _____

Maternity: Number of pregnancies: _____

Number of Children: _____

I hereby authorize Aesthetic Surgery Associates to furnish information to the insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents.

SIGNATURE _____ **DATE** _____