Tulsa Surgical Arts
OKLAHOMA COSMETIC SURGERY CENTER

Patient Information

Name _____ DOB _____

Address _____

Phone _____ Email _____

Employer _____ Occupation _____

Gender _____ Weight _____ Height _____ # of children _____

Marital Status: Married Single Divorced Separated Widowed

Name of Spouse _____ Spouses Phone _____

In case of emergency, contact _____

Relationship _____ Phone _____

Who is responsible for charges? _____ Pharmacy information _____

Referral Source _____ Reason for visit _____

Surgeries of Interest

Circle all that apply

Arms	Breast Enlargement	Breast Lift	Breast Reduction Cheeks	Chin
Ears	Eyelid	Face	Liposuction	Nose
Wrinkles	Tummy Tuck	Other	Mouth	Neck

Please provide any information that would be helpful for your consultation: _____

Medical Health History

The medical history is an extremely important part of your consultation. It helps to alert us to any potential problems that might interfere with your surgery. Please take the time to fill this out completely and accurately. If you need some help, the staff will be glad to assist you.

Do you have an advanced directive or living will? (circle) YES NO

List ALL prescription drugs you are taking: _____

List ALL non-prescription drugs you take (I.e. aspirin, herbal medicines, etc.) _____

List ANY diet pills you take [[VERY IMPORTANT!]] Can cause serious problems with anesthesia _____

List ANY drugs to which you are ALLERGIC _____

List ANY contact allergies including latex or other products _____

Please tell us about ANY serious illnesses you have had in the past: For example, heart disease, blood pressure problems, pulmonary disease, kidney disease, diabetes, thyroid trouble, stomach ulcers, etc. _____

Please list any operations you have had (including cosmetic surgery) Give approximate dates _____

Describe ANY difficulties you have had with anesthesia _____

Describe ANY MAJOR injuries you have sustained (include dates) _____

Are there any hereditary disorders in your family that might be of significance? _____

_____

Do you smoke? _____If so, what form and how much? _____

Do you drink alcohol? (circle) None Occasional Moderate Heavy

Do you now or have you ever had an addiction to controlled narcotics or street drugs? _____

_____

How is your general health? (circle) Poor Fair Good Excellent

Are you under a doctor's care? _____If yes, who? _____

Circle all that apply

Tubal Litigation
Hysterectomy
Post-Menopausal
Severe dryness of the eyes Glaucoma or blurry vision
Complications after surgery
Chronic skin condition
Recurrent severe dizziness
Severe headaches
Chronic sinus problems or nasal blockage
Recurrent fever blisters
Paralysis of the face
Asthma or emphysema
Chronic hoarseness
Shortness of breath
Chest pain

Heart disease/high blood pressure
Chronic abdominal problems
Kidney or bladder problems
Blood in bowel movements
Blood in urine or trouble urinating
Bleeding disorders (you or anyone in your family)
Easy bruising
Menstrual disorder
Abnormal lump or node
Problems with bones or joints
Unexplained weight loss
Cancer
Emotional/Psychological problems
Bad surgical result or unsatisfactory medical care

Please Explain:

_____

_____

_____

_____

I HAVE READ THIS FORM ENTIRELY AND HAVE COMPLETED IT FULLY AND ACCURATELY TO THE BEST OF MY KNOWLEDGE.

Date this form was completed_____ Patient Signature_____