# PLASTIC SURGICAL SPECIALIST

Independent Plastic Surgeons

JD Stuart, M.D.
Cisco Sanchez-Navarro, M.D.

## Patient Interest Questionnaire

Patient Name: _____ Date: _____

**Facial Skin/Fine Lines & Wrinkles (please check all that apply)**

- ☐ Facial Plastic Surgery
- ☐ Facial Fullness/Drooping
- ☐ Facial Contouring
- ☐ Drooping Brow
- ☐ Drooping Eyelids
- ☐ Puffy Lower Lids
- ☐ Neck Wrinkles
- ☐ Frown Lines/Fine Lines/Wrinkles
- ☐ Nose Shape
- ☐ Ears
- ☐ Cheeks, Chin
- ☐ Botox/Dyspor
- ☐ Fillers (Bellafill, Restylane)
- ☐ Thin Lips
- ☐ Laser Resurfacing
- ☐ Deep FX
- ☐ Microneedling/PRP
- ☐ Brown Spots/Age Spots/Skin Texture
- ☐ Skin Care
- ☐ Hair Loss/Hair Transplantation
- __ Other, please specify: _____

**Upper Body (please check all that apply)**

- ☐ Breast Size/Shape
- ☐ Arms
- ☐ Back

**Lower Body:**

- ☐ Abdominal Area
- ☐ Hips/Legs
- ☐ Body Contouring
- ☐ Body Lift
- ☐ Labiaplasty

**Have you ever seen our Website? What do you think of it?** _____

Please let us know if we can assist you with any other information on cosmetic procedures.

| Plastic Surgical Specialists<br>**Independent Plastic Surgeons**<br><br>J.D. Stuart, MD<br>C. Francisco Sanchez-Navarro, MD | **PATIENT REGISTRATION**<br>**Please Print**<br><br>Please include parents' information if patient is a minor | **Office Use Only**<br><br>Date Completed _____<br>Date Updated _____ |
|---|---|---|

Patient's Last Name _____ First Name _____ Middle _____

☒Child ☐Single ☐ Married ☐Widowed ☐Divorced ☐ Separated

Social Secure Number: _____/_____/_____ Date of Birth: ____/_____/_____ Age: _____

Address (Street, Apt #): _____

City: _____ State: _____ Zip Code: _____ Phone Number: (___) ____ - _____

Employed By: _____ Occupation _____ Bus. Phone: (___) ____ - _____

Employer's Address: _____

Spouses'/Parent's Name: _____ Employed By: _____ Occupation _____

Employer's Address: _____

Patient's Email Address: _____

Name of Preferred Pharmacy: _____ Phone: (___) ____ - _____

Reason for Consultation:

_____

_____

Referred by: _____

* I understand that a fee is charged for all first visits, examinations and medical reports.

** AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS: I hereby authorize Plastic Surgical Specialists to release any information, except HIV Testing and Positive Status, acquired in the course of my examination or treatment and further authorize payment directly to the physicians of the surgical and/or medical benefits. I understand I am financially responsible for all charges.

*** I agree to pay for all costs of collection, including reasonable attorney fees.

Signature: _____ Date: _____

*Patient or Responsible Party*

## General

Height: _____ Present Weight: _____ Do you smoke or use any nicotine products? ☐Yes ☐No

If Yes, How much? _____

Are you allergic to any pills, drugs or medicine? Yes No If Yes, please comment: _____

Please list all medications you are now taking (including birth control pills, diuretics (water pills), blood pressure or heart medications, tranquilizers, hormones, steroid medications, cortisone, blood thinners, aspirin, Accutane, retina, vitamins, supplements, any over the counter meds):

_____

_____

| | | |
|---|---|---|
| Have you ever had a REACTION to a GENERAL anesthetic? (Being put to sleep) | ☐Yes | ☐No |
| Have you ever had a REACTION to LOCAL anesthetic? (Example Novocain, etc) | ☐Yes | ☐No |
| Do you have high blood pressure? | ☐Yes | ☐No |
| Do you form heavy scars? | ☐Yes | ☐No |
| Do you have frequent infections or boils? | ☐Yes | ☐No |
| Have you ever had any excessive bleeding problems? | ☐Yes | ☐No |
| Have you ever had any significant emotional problems? | ☐Yes | ☐No |
| Have you ever had, or been advised to have, psychiatric care? | ☐Yes | ☐No |
| Have you ever seen other plastic surgeons about the SAME problems which brings you here? | ☐Yes | ☐No |
| Have you had a blood transfusion since 1980? | ☐Yes | ☐No |
| Do you have MRSA? | ☐Yes | ☐No |
| Do you have Hep C? | ☐Yes | ☐No |
| Are you in a significant HIV risk group? | ☐Yes | ☐No |
| Are you HIV (AIDS virus) positive? | ☐Yes | ☐No |
| Do you have a personal or family history of breast cancer? | ☐Yes | ☐No |
| Have you had a DVT/PE? (Blood Clot) | ☐Yes | ☐No |
| Do you exercise regularly? | ☐Yes | ☐No |
| Have you had any past or present heart/cardiac problems? | ☐Yes | ☐No |

## Local Problems

Have you ever had any serious illness of the following?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Brain | ☐Yes | ☐No | Intestine | ☐Yes | ☐No | Extremities | ☐Yes | ☐No |
| Eyes | ☐Yes | ☐No | Abdomen | ☐Yes | ☐No | Diabetes | ☐Yes | ☐No |
| Arthritis | ☐Yes | ☐No | Urinary | ☐Yes | ☐No | Jaundice | ☐Yes | ☐No |
| Joint Problems | ☐Yes | ☐No | Kidney | ☐Yes | ☐No | Other | ☐Yes | ☐No |
| Nose | ☐Yes | ☐No | Bleeding | ☐Yes | ☐No | | | |
| Breasts | ☐Yes | ☐No | Reproduction | ☐Yes | ☐No | | | |
| Lungs | ☐Yes | ☐No | Nervous | ☐Yes | ☐No | | | |
| Heart | ☐Yes | ☐No | Collagen | ☐Yes | ☐No | | | |

If checked, please explain:

_____

_____

## Maternal History

Have you ever been pregnant? _____ If yes, how many times? _____
How many children do you have? _____ Could you be pregnant? _____

**Previous Surgery (please list)**

Operation: _____ Year _____

Complication, If Any _____

## Serious Injuries

Type and Date Occurred

_____
_____

## Acknowledgement of Receipt of Privacy Health Information Practices

I have been presented with a copy of PLASTIC SURGICAL SPECIALISTS Notice of Privacy Health Information Practices detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restrictions concerning the use of my personal medical information:

_____
_____
_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ Date: _____

If not signed by patient, please indicate relationship to patient (i.e. spouse)

Relationship: _____ Witnessed by: _____