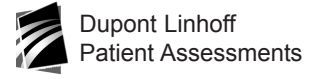


# Plastic and Cosmetic Surgery Intake Summary



Name: Mary Sample  
ID: 22222222  
Date: 2/26/2008

Gender: Female  
Age: 43  
Session: First Visit

### Area of Concern for Surgery

Face (Nose), Breast  
Currently uses cosmetics for area of concern: Yes

### Allergies

Type	Reaction	Treatment
Medications/Antibiotics	Rash	
Animals	Sneeze	Over-the-counter medications

### Medications

Current Prescriptions	Pain medications, Hormones
Past Prescriptions	Pain medications, Anti-inflammatories, Other
Current OTC Medications	Vitamins, Supplements, Other

### Smoking / Alcohol

Current smoker: 2 packs perday, pst maximum 3 packs per day, started at age 17  
Daily drinks: 2 wine, 0 Beer, 0 Liquor

### Prior Anesthesia

	Year	Complications	Notes
Prior #1	2007	Yes	_____
Prior #2	2006	No	_____

### Prior Cosmetic Surgeries

	Year	Area	Complications	Satisfaction	Notes
Prior #1	2007	Abdomen	Yes	Satisfied	_____
Prior #2	2006	Breast	Yes	Dissatisfied	_____

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**Current Problems**

Skin	No	Lung	Yes
Heart	No	Blood clotting (thrombosis)	Yes
Diabetes	No	High blood pressure	Yes
Visual, hearing or dental	No	Joint or muscle	Yes
Gastrointestinal, stomach or bowel	No	Bleeding	No
Abnormal weight gain or loss	No	Dental surgery	Yes
Psychiatric counseling	No	Numbness, weakness, tremor or dizziness	Yes
Gynecological treatment or surgeries	Yes		
Pregnant: Three times		Live birth: Two times	

**Past Problems**

Skin	Yes	Lung	No
Heart	No	Blood clotting (thrombosis)	No
Diabetes	No	High blood pressure	Yes
Visual, hearing or dental	Yes	Joint or muscle	No
Gastrointestinal, stomach or bowel	Yes	Bleeding	No
Abnormal weight gain or loss	Yes	Dental surgery	No
Psychiatric counseling	Yes	Numbness, weakness, tremor or dizziness	Yes

**Family History**

High blood pressure, Heart problems, Neurological problems

**Wellness**

Current Activities: Ski, Swim, Hike, Regular fitness exercise program

Are you currently exercising regularly?	Yes
How many times a week?	Three times
How long to you exercise	1/2 hour
Are you interested in an exercise / fitness evaluation?	Yes
Have you lost or gained weight (0 - 15 lbs) over the past year?	Yes
Are you interested in a nutritional consult / evaluation?	Yes
Have you had an updated professional beauty cosmetic evaluation in the past year?	No
Have you seen a Dermatologist or Specialist for hair removal, pigment or other skin or body issues?	Yes
Are you seeing a dentist regularly?	Yes
Are you interested in a cosmetic dental evaluation?	Yes

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**Psycho-Social**

Do you feel anxious?	Yes	Do you feel stressed or restless?	Yes
Do you have trouble sleeping; low energy, tiredness?	No	Do you feel you have trouble concentrating?	Yes
Do you have poor appetite (weight loss)?	No	Do you have significant weight gain?	No
Do you feel you have loss of energy or fatigue?	Yes	Do you feel worthless?	Yes
Do you feel you have difficulty completing tasks either at home or work?	No	Do you have a decreased need for sleep?	Yes
Do you have more energy than usual?	Yes	Do you feel tearful or crying?	No
Do you feel slowed down?	Yes	Do you feel physical restlessness?	No
Have you lost interest or enjoyment of sex?	No		
Do you have unexplained episodes of ... Shortness of breath?	Yes	Do you have unexplained episodes of ... Chest pain, discomfort or heart palpitations?	No
Do you have unexplained episodes of ... Dizziness or unsteady feelings?	Yes	Do you have unexplained episodes of ... Tingling of hands or feet?	No
Do you have unexplained episodes of ... Hot or cold flashes?	Yes	Do you have unexplained episodes of ... Sweating?	No
Do you have unexplained episodes of ... Faintness?	Yes	Do you have unexplained episodes of ... Trembling or shaking?	No
Do you have unexplained episodes of ... Feeling out of it?	Yes	Do you have unexplained episodes of ... Smothering sensations?	Yes
Do you feel anxious?	No	How often do these feelings occur?	Once a week
Do you have or had ... Difficulty swallowing, loss of voice, deafness?	No	Do you have or had ... Blurred vision or blindness?	Yes
Do you have or had ... Fainting spells?	No	Do you have or had ... Memory loss?	Yes
Do you have or had ... Seizures?	No	Do you have or had ... Trouble walking, paralysis or muscle weakness?	Yes
Do you have or had ... Abdominal pain, nausea, vomiting?	No	Do you have or had ... Bloating, gas, diarrhea, constipation?	Yes
Do you have or had ... Pain in back, joints, extremities?	No		