

CHRYSALIS COSMETICS

PATIENT INFORMATION

Date: ____/____/____

Name: [First] _____ [M.I.] _____ [Last] _____ Male | Female
Address: _____ [Apt.] _____ Age: _____ D.O.B: ____/____/____
City: _____ State: _____ Zip: _____
Social Security #: _____ Drivers License #: _____ Home Tel: _____
Work Tel: _____
Mobile Tel: _____
E-mail: _____ @ _____

EMPLOYMENT INFORMATION

Full Time | Part Time | Student | Retired | Other Occupation: _____
Employer/School: _____ Work Tel: _____

EMERGENCY CONTACT

Name: [First] _____ [Last] _____ Home Tel: _____
Relationship to Patient: _____ Work Tel: _____
Address: _____ Mobile Tel: _____
City: _____ State: _____ Zip: _____

REFERRAL INFORMATION

Referring Physician/Patient/Source: _____
How did you hear about Dr. Perry? _____
Have you been to our website [www.SacramentoPlastics.com]? Yes | No

PROCEDURE INFORMATION

What is the reason for your visit today? [Check all applicable procedures below]

FACE	BREAST	BODY	SKIN
<input type="checkbox"/> Facelift	<input type="checkbox"/> Breast Augmentation	<input type="checkbox"/> Liposuction	<input type="checkbox"/> Botox Cosmetic
<input type="checkbox"/> Cheek Lift	<input type="checkbox"/> Breast Lift (Mastopexy)	<input type="checkbox"/> Tummy Tuck	<input type="checkbox"/> Facial Fillers
<input type="checkbox"/> Brow Lift	<input type="checkbox"/> Breast Revision / Repair	<input type="checkbox"/> Mommy Makeover	<input type="checkbox"/> Fat Injections
<input type="checkbox"/> Neck Lift	<input type="checkbox"/> Breast Implant Exchange	<input type="checkbox"/> Body Lift	<input type="checkbox"/> Skin Resurfacing
<input type="checkbox"/> Liquid Facelift	<input type="checkbox"/> Breast Capsulectomy	<input type="checkbox"/> Buttock Augmentation	<input type="checkbox"/> Skin Tightening Laser
<input type="checkbox"/> Facial Fat Transfer	<input type="checkbox"/> Breast Reduction	<input type="checkbox"/> Arm Lift (Brachioplasty)	<input type="checkbox"/> Hand Rejuvenation
<input type="checkbox"/> Facial Implants	<input type="checkbox"/> Breast Asymmetry	<input type="checkbox"/> Thigh Lift	<input type="checkbox"/> Hyperhidrosis
<input type="checkbox"/> Lip Augmentation	<input type="checkbox"/> Male Breast Surgery	<input type="checkbox"/> Fat Transfer	<input type="checkbox"/> Skin Care
<input type="checkbox"/> Chin Augmentation	Other: _____	Other: _____	Other: _____
<input type="checkbox"/> Ear Reshaping	_____	_____	_____
<input type="checkbox"/> Upper Eyelids			
<input type="checkbox"/> Lower Eyelids			
<input type="checkbox"/> Rhinoplasty			
Other: _____			

Please describe why you are interested in having the procedure(s) listed above: _____

Have you consulted with other physicians about procedure(s) indicated above? Yes | No

Is this procedure a revision from a previous surgery? Yes | No If yes, how many _____

SURGERY SCHEDULING QUESTIONNAIRE

To help us understand your needs and time preferences for your surgery, please provide us with the following information:

What is your time preference for your Procedure? Within the next: 1 Month | 3 Months | 6 Months | 1 Year

HEALTH INFORMATION

Primary Care Physician: _____ Other Physicians: _____ Weight: _____ Height: _____

PERSONAL MEDICAL HISTORY

Do you have any chronic medical problems? [Fill in box for those that apply]

- High Blood Pressure Diabetes Heart Disease Kidney Disease Stroke Heart Failure
- Stomach Problems Seizures Liver Disease Bleeding Problems Emphysema Cancer
- Heart Attack Hepatitis Chest Pain Gastric Reflux Asthma HIV or AIDS
- Psychiatric Diagnosis Other: _____

Is there a personal or family of anesthetic complications or malignant hyperthermia? Yes | No

If yes, please explain? _____

FAMILY HISTORY

Do you have a family history of any medical problems? _____

Please indicate Family member(s): _____

Please list all prior Operations:

Date

List any complications:

- | | | |
|----------|----------------|-------|
| 1. _____ | ____/____/____ | _____ |
| 2. _____ | ____/____/____ | _____ |
| 3. _____ | ____/____/____ | _____ |

Please list all prior Hospitalizations:

Date

List any complications:

- | | | |
|----------|----------------|-------|
| 1. _____ | ____/____/____ | _____ |
| 2. _____ | ____/____/____ | _____ |
| 3. _____ | ____/____/____ | _____ |

Please list ALL CURRENT medications and/or dietary supplements including:

(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins, and Herbal Supplements)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Please list ALL allergies and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc.) _____

SOCIAL HISTORY

Do you use Blood Thinners? (i.e. Coumadin/Heparin/Ibuprofen) Yes | No If Yes, medication name: _____

Have you used Diet Pills in the last two (2) weeks? Yes | No If Yes, medication name: _____

Have you taken Steroids / Accutane within the last year? Yes | No If Yes, medication name: _____

