

**COSMETIC SURGERY AT UNIVERSITY POINTE
COSMETIC PATIENT EVALUATION**

Patient Name _____ F M Date _____

Date of Birth _____

Address _____ City _____

State _____ ZIP _____

E-Mail _____

May we E-mail you? Yes _____ No _____

Home Telephone _____ may contact me _____ may leave a message

Mobile Telephone _____ may contact me _____ may leave a message

Office Telephone _____ may contact me _____ may leave a message

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Conditions/Goals:

I am here today because I: _____

My goals for plastic surgery include: _____

I would describe the present condition(s) I wish to improve as: _____

Health History:

I am **ALLERGIC TO THE FOLLOWING MEDICATIONS:** _____

I have the following additional **ALLERGIES:** _____

I have had the following **SURGERIES:** _____

I am presently under a **DOCTOR'S CARE** for the following conditions: _____

I have the following **MEDICAL CONDITIONS:** _____

I would describe my **PRESENT STATE OF HEALTH** as: _____

I take the following medications, hormonal supplements, vitamins, herbal supplements: _____

Background

I was referred to Dr. _____ by

Friend/Relation/Existing PT: _____

Web: www.Cosmeticsurgeryuc.com www.loveyourlook.com Google
 www.surgery.org other site _____

Advertising:

- Yellow Pages
- Pulse Journal
- Pulse Journal Online
- Mason Pulse
- + West Chester Journal
- Kings/Little Miami Pulse Journal
- Middletown Journal
- Latinos Magazine
- Cincinnati Magazine
- In Touch
- New Beauty
- Article / News

- Open House _____
- Seminar _____

Other _____

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Whom may we contact in an emergency?

Name: _____ Relationship: _____

Telephone: _____ Mobile: _____

Address: _____

I attest the above history is completed to the best of my knowledge and understand and accept that my failure to disclose any of the above information can adversely affect a prescribed course of treatment to meet my goals, my safety, or the outcome of any treatment I elect to undergo with Dr. _____ or any member of his staff.

Patient signature _____

Date _____