COSMETIC SURGERY SPECIALISTS
Alan B. Brackup, M.D., F.A.C.S.

PLEASE PRINT and COMPLETE ALL INFORMATION

Appointment Date: ______________________

Patient Name: __________________________________ ______ ______________________________________
First MI Last

Address: ____
Street # and Name City State Zip

Date of Birth: _____/_____/_____ Age: _____ Sex: _____ M _____ F Height: ______ Weight: ______

S.S. # __________________________ S _____ M _____ D _____ W _____ Spouse Name: ______________________

Telephone: Home: ______/______/______ Cell: ______/______/______ Work: ______/______/______

May we contact you by email? ___ Y ___ N Email address (PRINT):____

Your occupation: __________________________________ Your Employer: ___________________________________

Employer Address: ____

Emergency Contact: ____
Name Relationship Phone #

*How did you hear about our office? ____

Family Physician: __________________________________ Phone: ___________________ Fax: ___________________
First Last

Physician's Address ____
Street # and Name Suite # City State Zip

Referring Physician: ____ Phone: ______________________________
(if other than family physician)

Pharmacy Name & Phone Number: ____

Please tell us <u>your</u> reason for today's appointment: ____
____

Have you had previous surgery including cosmetic surgery? ___ Yes ___ No If yes, please list procedure(s):
____

Were there any complications: ___ Yes ___ No If yes, please list complications:
____

Have you or a family member had any problems with anesthesia? ___ Yes ___ No If yes, please list:
____

Have you ever consulted or been treated by a psychiatrist or psychologist? ___ Yes ___ No If yes, please explain:
____

Are you, or might you be pregnant? ___ Yes ___ No ___ Not Applicable

Are you **ALLERGIC TO LATEX?** ___ Yes ___ No

Are you **ALLERGIC TO ANY <u>MEDICATIONS</u>:** ___ Yes ___ No

If **yes**, please list medicine allergies: ____

List **<u>All Medications</u>** you are presently taking including strength and how often:

1.________________________________ mg __ X a day 5.________________________________ mg __ X a day
2.________________________________ mg __ X a day 6.________________________________ mg __ X a day
3.________________________________ mg __ X a day 7.________________________________ mg __ X a day
4.________________________________ mg __ X a day 8.________________________________ mg __ X a day

(additional medications, please use the back of this sheet)

Do you take blood thinners, aspirin or non-steroidal anti-inflammatory (NSAIDs) products? ___ Yes ___ No
Please list: ____

Please list ALL vitamins, supplements, and any type of herbal products you are presently taking:
____

Do you presently smoke? ___ Yes ___ No If yes, amount per day _____ How long? _____
Have you ever smoked? ___ Yes ___ No If yes, amount per day _____ How long? _____

How much alcohol do you consume in one week? ___ None ___ Light ___ Moderate ___ Heavy
Are you currently under treatment for alcohol or drug abuse? ___ Yes ___ No

Have you ever had Tuberculosis (TB)? ___ Yes ___ No
Have you ever been exposed to Tuberculosis (TB) within the past year? ___ Yes ___ No

Do you have a history of eye problems, dry eyes or eye surgery? ___ Yes ___ No
If yes, please explain: ____

Do you wear glasses? ___ Yes ___ No Do you wear contacts? ___ Yes ___ No

Do you have any personal history of hypertrophic (keloid) scar anywhere on your body? ___ Yes ___ No
If yes, what are? ____

Do you have any personal history of skin cancer? ___ Yes ___ No
If yes, please explain: ____

Have you had radiation treatment to your face? ___ Yes ___ No
If yes, please explain: ____

Have you received a chemical peel, dermabrasion, or laser resurfacing? ___ Yes ___ No
Any complications, please explain: ____

Have you, or do you currently use Retin-A or glycolic acids for skin care? ___ Yes ___ No

**** Have you ever had or been treated for any of the following: (please check all that apply)**

_ high blood pressure
_ stroke
_ heart attack/MI
_ chest pain/pressure
_ palpations
_ shortness of breath
_ heart murmur
_ congestive heart failure
_ pacemaker/AICD
_ mitral valve prolapse/MVP
_ bleeding disorder/blood clot/DVT
_ rheumatic/scarlet fever
_ thyroid problems
_ diabetes

_dizziness/passing out spells
_ neuritis
_ frequent/severe headaches
_ epilepsy/seizure disorder
_ anxiety
_ excessive worry/depression
_ excessive tiredness/fatigue
_ arthritis/joint pain
_ pain/shoulders/arms/hands
_ weakness/numbness in a limb
_ swelling of ankles or feet
_ back problems/pain
_ bone disease/broken bones
_ gout

_ severe ear, nose, throat trouble
_ prolonged hoarseness
_ coughing/vomiting blood
_ emphysema/COPD/lung problems
_ pneumonia
_ chronic cough/recent cold
_ sinus trouble
_ asthma/wheezing
_ skin rash/skin disease
_ allergies/hay fever
_ chills/fever/night sweats
_ anemia
_ liver disease/jaundice/hepatitis
_ AIDS/ARC

_ eye injury/disease
_ double vision/blindness
_ cataract/glaucoma
_ bladder infections
_ kidney stone/blood in urine
_ frequent urination
_ constipation
_ repeated diarrhea/bleeding
_ indigestion/GERD/reflux
_ peptic/stomach ulcer
_ loss of appetite
_ nausea/vomiting
_ recent gain/loss of weight

********** PHYSICIAN ONLY **********
By signing below, I attest I have reviewed the above information with the patient.

<u>Physician Signature Only</u> ____ ________________
Alan B. Brackup, M.D. **Date**