INSTITUTE OF PLASTIC SURGERY

Krishna Dash, M.D. Rupesh Jain, M.D.

PATIENT DEMOGRAPHIC INFORMATION

LAST NAME	FIRST NAME	MIDDLE	TODAY'S DATE

SEX	DATE OF BIRTH	AGE	SOCIAL SECURITY #	DRIVER'S LICENSE #
☐ Male ☐ Female	/ /			

ADDRESS	MAY WE SEND INFORMATION TO THIS ADDRESS? ☐ YES ☐ NO
Street	
City	State Zip

EMAIL:		May we email you at this address? ☐ YES ☐ NO
HOME:		May we call you at this number? ☐ YES ☐ NO
CELL:		May we call you at this number? ☐ YES ☐ NO
WORK:		May we call you at this number? ☐ YES ☐ NO

PREFERRED CONTACT METHOD TO CONFIRM APPOINTMENT (CHECK ALL THAT APPLY)

☐ Email ☐ Cell# ☐ Home# ☐ Work# ☐ _____

HOW DID YOU HEAR ABOUT US?

☐ Friend / Family: _____

☐ Physician: _____

☐ Internet: _____

☐ Reputation / Word of mouth

☐ Other: _____

OCCUPATION	
EMPLOYER	
EMPLOYER PHONE#	

EMERGENCY CONTACT PERSON

NAME	
RELATIONSHIP	
HOME #	
CELL #	

PRIMARY INSURANCE (for non-cosmetic procedures)

Subscriber's Name	
Relationship to patient	
Birth Date	
Social Security #	
Insurance Co.	
ID #	
Group #	
Primary Care Physician	

SECONDARY INSURANCE (for non-cosmetic procedures)

Subscriber's Name	
Relationship to patient	
Birth Date	
Social Security #	
Insurance Co.	
ID #	
Group #	

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PATIENT MEDICAL INFORMATION

LAST NAME	FIRST NAME	MIDDLE	TODAY'S DATE
Height:	**Current Weight:**	**Lifetime Highest Weight:**	

REASON FOR VISIT (CHECK ALL THAT APPLY)

FACE	BREAST	BODY	SKIN & NON-SURGICAL
☐ Face / Neck Lift	☐ Breast Augmentation	☐ Liposuction	☐ Mole Removal
☐ Brow / Forehead Lift	☐ Breast Lift	☐ CoolSculpting	☐ Scar Revision
☐ Eyelid enhancement	☐ Breast Reduction	☐ Tummy Tuck	☐ Botox / Dysport / Xeomin
☐ Ear Pinning	☐ Male Breast Surgery	☐ Thigh Lift	☐ Skin care
☐ Nose shape or size		☐ Arm Lift	☐ Wrinkles
☐ Chin (too large or small)		☐ Buttock / Brazilian Lift	☐ Skin /Tissue Fillers
☐ Cheek Enhancement		☐ Labial Reduction	☐ Lip Enhancement
☐ Laser		☐ Body Contouring after Weight Loss	☐ Cellulite Reduction
☐ Skin Tightening			☐ Skin Tightening
☐ Other:_____	☐ Other:_____	☐ Other:_____	☐ Other:_____

ALLERGIES TO MEDICATIONS & THE REACTION

MEDICATIONS AND DOSAGE

PLEASE LIST ALL MEDICAL PROBLEMS (eg, Diabetes, High Blood Pressure, Heart Disease, etc.)

SURGERIES AND THEIR DATES

HAVE YOU EVER HAD:			DO YOU TAKE:		
Uncontrolled Bleeding	☐ NO	☐ YES	Birth Control Pills	☐ NO	☐ YES
Blood Clotting Problems	☐ NO	☐ YES	Hormone Replacement Pills	☐ NO	☐ YES
Problems with Anesthesia	☐ NO	☐ YES	Fish Oil	☐ NO	☐ YES
Family w/ Anesthesia Problems	☐ NO	☐ YES	Aspirin	☐ NO	☐ YES
Heart Attack	☐ NO	☐ YES	Ibuprofen (eg, Advil, Motrin)	☐ NO	☐ YES
Stroke	☐ NO	☐ YES	Vitamin E	☐ NO	☐ YES
Breast Cancer	☐ NO	☐ YES	Alleve, Naprosyn	☐ NO	☐ YES
	☐ NO	☐ YES	Herbal Supplements	☐ NO	☐ YES

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LAST NAME:		FIRST NAME:	

DO YOU USE:

Alcohol ☐ NO ☐ YES If so, how many drinks _____ per day / week (Circle one).

Cigarettes ☐ NO ☐ YES If so, how many packs _____ per day / week (Circle one). For how many years: _____

Marijuana ☐ NO ☐ YES If so, how many drinks _____ per day / week (Circle one).

Other Drugs: _____

BREAST CONSULT PATIENTS ONLY

Date of Last Mammogram: _____ Current Bra Size: _____

Where was it done: _____ Desired Bra Size: _____

Was it ABNORMAL? ☐ NO ☐ YES Have you had breast cancer? ☐ NO ☐ YES

If abnormal, what were the findings: _____ Family member with breast cancer? ☐ NO ☐ YES

PREGNANCY HISTORY

Have you ever been pregnant? ☐ NO ☐ YES Number of pregnancies: _____ Number of deliveries: _____

DO YOU NOW OR HAVE YOU HAD ANY OF THE FOLLOWING (CHECK IF YES):

☐ Hay Fever
☐ Lupus
☐ Scleroderma
☐ Sjogren's
☐ Ehler Danlos

☐ Chest Pain
☐ Heart Murmur
☐ High Blood Pressure
☐ Pacemaker
☐ Heart Attack
☐ Defibrillator

☐ Chills
☐ Fever
☐ Weight Loss

☐ Frequent Nose Bleeds
☐ Sinus Problems

☐ Diabetes
☐ Thyroid problems
☐ Kidney Stones
☐ Painful Urination
☐ Urinary Frequency
☐ Urinary Retention

☐ HIV/AIDS
☐ Breast Cancer
☐ Basal or Squamous Cell Skin Cancer
☐ Melanoma
☐ Bleeding Tendency
☐ Blood Clotting Problems

☐ Arthritis
☐ Back Pain
☐ Gout
☐ Neck Pain
☐ Osteopenia
☐ Osteoporosis

☐ Double Vision
☐ Frequent Dry Eyes
☐ Glaucoma

☐ Hepatitis
☐ Indigestion / Reflux Disease
☐ Liver Disease

☐ Keloids / Thick Scars

☐ Alzheimer's
☐ MS
☐ Seizures
☐ Stroke
☐ Anxiety
☐ Bipolar Disorder
☐ Depression
☐ Schizophrenia

☐ COPD
☐ Chronic Cough
☐ Pulmonary Embolus
☐ Asthma

☐ Anesthesia Issues
☐ Family with Anesthesia Problems

FAMILY MEDICAL HISTORY- Has anyone in your family had:

Bleeding Disorder ☐ NO ☐ YES
Blood Clotting Disorder ☐ NO ☐ YES
Breast Cancer ☐ NO ☐ YES
Problems with Anesthesia ☐ NO ☐ YES
Malignant Hyperthermia ☐ NO ☐ YES

Other: _____

2438 Research Pkwy, Suite 100 Colorado Springs, CO 80920 P: 719.535.9990 F: 719.535.9980 WWW.INSTITUTEOFPLASTICS.COM