Liu Plastic Surgery

Welcome to Liu Plastic Surgery, your Partnership for Excellence.

We are a partnership for excellence both between two surgeons and between us and you, the patient. We are extremely proud of the relationship we develop with our patients and it is this sacred relationship that forms the cornerstone of our practice. Our commitment to you, the patient, is first and foremost to be your physician and your advocate for life.

Patient Name: ____ Date: ________________________

Date of Birth: _______________________ Age: _________Height:_______ Weight: _______ BMI: ____________

Address: ____

Home Phone: ___________________________ Mobile Phone: __________________________

E-Mail Address: __________________________ Best Way to Reach You ❑ Home ❑ Mobile ❑ Email

By signing below I approve to receive information: ____

Patient Signature

Whom may we thank for this referral (How did you find our practice?):____________________________________

Main Concern(s) of Today's Consultation is: ____

Personal Physician

Name	
Specialty	
Address	
Telephone	
Date last exam	
Results	

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Medical History (Please check if you currently have, or have had, any of the following)

	Yes	No		Yes	No
Diabetes (High Blood Sugars)	❑	❑	Thyroid (High or Low)	❑	❑
High Blood Pressure	❑	❑	Recent Sickness / Flu / Cold / HIV-AIDS	❑	❑
Heart Attack / Disease / Problems	❑	❑	Kidney Problems / Dialysis	❑	❑
Irregular Heart Beat	❑	❑	Skin Disorders / Skin Cancer	❑	❑
Lung Disease / Asthma / COPD	❑	❑	Hepatitis / Liver Failure / Liver Disease	❑	❑
Shortness of Breath / Chronic Cough	❑	❑	Herpes / Fever Blisters / Shingles	❑	❑
Ulcers / GI Bleed / GERD / Reflux	❑	❑	Dry Eyes / Burning / Vision Problems	❑	❑
Fainting / Blackout / Stroke	❑	❑	Anemia (Low Blood Count) / Transfusions	❑	❑
Muscle Weakness / Fatigue / Twitch	❑	❑	Sickle Cell Disease / Blood Disease	❑	❑
Lower Back Pain / Neck Pain	❑	❑	Lupus / Rheumatoid / Autoimmune Disease	❑	❑
Prolonged Bleeding / Abnormal bleeding	❑	❑	History of Cancer	❑	❑
Blood Clots / Deep Venous Thrombus	❑	❑	Recently Hospitalized? Date: ___________	❑	❑
Others (Not Listed):					

Surgical History (Please list all operations you have had)

Date	Operation	Date	Operation

Has anyone in your family had a reaction to general anesthesia? ❑ Yes ❑ No
If yes, please explain:

Current Medications (Please list ONLY the medications you currently take)

Medication	Dosage	Medication	Dosage	Medication	Dosage

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Health Supplements/Herbs/OTC: Please list all substances that you take (e.g. fish oil, ginseng, etc.)

	Yes	No		Yes	No
Do you use any diet pills?	❑	❑	Do you take Ginseng?	❑	❑
Do you use St John's Wort?	❑	❑	Do you take Omega-3 (fish oil)? or Vit-E	❑	❑
Do you take any other medications?	❑	❑	Do you use any non-prescription medication or drugs not already listed?	❑	❑

If yes to any of the above, please list dosage and times you take it:

Medication	Dosage	Last time taken

Allergies

Agent	Reaction
Medication(s)	[ ] None
Tapes (Type)	[ ] None
Soap(s)	[ ] None
Food	[ ] None

Employment and Family

Employment: ❑ Yes ❑ No ❑ Retired Position:____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Partner Number of Children_____________

Personal Health Habits

Do you smoke, or have you ever smoked? ❑ Yes ❑ No

If yes, how many packs per day? If quit, when (year): ____________________

How many servings of alcohol (i.e. glass of wine, can of beer) do you drink per week? ❑ None

Do you use any "recreation" drugs? ❑ Yes ❑ No

Are you sexually active? ❑ Yes ❑ No

Scarring

Have you formed excessive or unsatisfactory scars in the past? ❑ Yes ❑ No

If yes, give locations:

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Bleeding/Transfusions

Have you taken aspirin, anti-inflammatory medications (NSAIDs) or blood thinners (Coumadin, Warfarin, Lovenox, etc) within the past two weeks? ❑ Yes ❑ No
If yes, please list:

Prolonged bleeding when cut and/or family history? ❑ Yes ❑ No
Have you had blood transfusions? ❑ Yes ❑ No
Have you experienced a reaction to a transfusion? ❑ Yes ❑ No
Do you have a blood relative with a bleed disorder like hemophilia or von Willebrand disease? ❑ Yes ❑ No
Have you ever had prolonged bleeding with surgical procedures, such as tonsillectomy? ❑ Yes ❑ No
Do you often get prolonged bleeding from trivial wounds or bruising with no apparent trauma? ❑ Yes ❑ No
Have you ever had spontaneous nosebleeds lasting more than 10 minutes? ❑ Yes ❑ No

Blood Clots / Deep Venous Thrombus (DVT)

Have you or anyone in your family had a blood clot or deep vein thrombosis? ❑ Yes ❑ No
Have you ever required anti-coagulation (blood thinning)? ❑ Yes ❑ No
If you answered yes to any of the above, please explain: ❑ Yes ❑ No

Women's Health

Is there any chance you could be pregnant? ❑ Yes ❑ No
Are you on birth control or hormone therapy (circle which one if yes)? ❑ Yes ❑ No
Age at first period: ___________________ Menopause: _____________________
Date of last menstrual period: _______________________
How many pregnancies: ___________ How many children: __________
Methods of delivery: ❑ C-section ❑ Vaginal ❑ Both
Did you breast feed? ❑ Yes ❑ No
Have you ever felt a breast mass? ❑ Yes ❑ No
If yes state location: _____________________ Date first noticed: ______________
Have you ever experienced breast discharge? ❑ Yes ❑ No
Do you regularly perform breast self-exams? If so, how often: _________________ ❑ Yes ❑ No
Personal History of Breast Cancer? ❑ Yes ❑ No
Family History of Breast Cancer? ❑ Yes ❑ No
Last Mammogram (date): ❑ Never
Breast biopsies/surgery (date): ❑ Never

Patient Name:____

Patient Signature:____

I certify that the above is true to the best of my knowledge.

Thank you for selecting Liu Plastic Surgery, your "*Partnership for Excellence.*"

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