

# 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**

<b>Name</b>	
<b>Specialty</b>	
<b>Address</b>	
<b>Telephone</b>	
<b>Date last exam</b>	
<b>Results</b>	

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

	Yes	No		Yes	No
Diabetes (High Blood Sugars)	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid (High or Low)	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Recent Sickness / Flu / Cold / HIV-AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack / Disease / Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems / Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorders / Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease / Asthma / COPD	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Liver Failure / Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath / Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Herpes / Fever Blisters / Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers / GI Bleed / GERD / Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Dry Eyes / Burning / Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Blackout / Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Anemia (Low Blood Count) / Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Weakness / Fatigue / Twitch	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease / Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>
Lower Back Pain / Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Lupus / Rheumatoid / Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Bleeding / Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	History of Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots / Deep Venous Thrombus	<input type="checkbox"/>	<input type="checkbox"/>	Recently Hospitalized? Date: _____	<input type="checkbox"/>	<input type="checkbox"/>
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

**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?	<input type="checkbox"/>	<input type="checkbox"/>	Do you take Ginseng?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use St John's Wort?	<input type="checkbox"/>	<input type="checkbox"/>	Do you take Omega-3 (fish oil)? or Vit-E	<input type="checkbox"/>	<input type="checkbox"/>
Do you take any other medications?	<input type="checkbox"/>	<input type="checkbox"/>	Do you use any non-prescription medication or drugs not already listed?	<input type="checkbox"/>	<input type="checkbox"/>

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

Medication	Dosage and Frequency	Last time taken

**Allergies**

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

**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

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."**