

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: _____

Additional cosmetic procedures or products of interest to you (please check all that apply):

- Latisse® Eyelash Growth Product
- BOTOX® Cosmetic or Dysport®
- Juvederm®, Restylane®, Radiesse®, Sculptra® Injectable Filler
- Skin Care Advice / Skin Care Products
- Facial Treatments / Micro-Dermabrasion
- Fat Grafting
- Laser Therapy
- Aesthetic (Cosmetic) Surgery
- Other, please specify _____

Select specific concerns regarding your skin/appearance (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Fine Lines/Wrinkles | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Dark Circles | <input type="checkbox"/> Shiny Areas |
| <input type="checkbox"/> Puffy Eyes | <input type="checkbox"/> Dry Skin/Dry Patches |
| <input type="checkbox"/> Blotchiness/Discoloration | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Dark Spots/Hyperpigmentation | <input type="checkbox"/> Dry Lips |
| <input type="checkbox"/> Eyelashes | |

Personal Physician

Name	
Specialty	
Address	
Telephone	
Date last exam	
Results	

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	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: _____

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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