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: _________Ht:_______ Wt: _______ Sex: ❑ Male ❑ Female

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®, Prevelle® Injectable Filler
- ❑ Skin Care Advice / Skin Care Products
- ❑ Facial Treatments / Micro-Dermabrasion
- ❑ Fat Grafting
- ❑ Laser Facial, Photofacial, Laser Hair Removal
- ❑ Aesthetic (Cosmetic) Surgery
- ❑ Other, please specify ____

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

- ❑ Fine Lines/Wrinkles
- ❑ Dark Circles
- ❑ Puffy Eyes
- ❑ Blotchiness/Discoloration
- ❑ Dark Spots/Hyperpigmentation
- ❑ Eyelashes
- ❑ Rosacea
- ❑ Shiny Areas
- ❑ Dry Skin/Dry Patches
- ❑ Acne
- ❑ Dry Lips

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Select the type of skin you believe you have:

- ❑ 1. Dry (dry all over, tight, easily irritated, sun-damaged, loss of softness, normal in the t-zone)
- ❑ 2. Normal (normal in the t-zone, normal on the sides of the face)
- ❑ 3. Oily (oily in the t-zone, normal to oily on the sides of the face, prone to breakouts)
- ❑ 4. Blemished (oily all over with frequent problematic breakouts)

Do you use a regular skincare routine now? Yes / No

List the products you currently use on a daily basis.

____

How often do you have facials?

- ❑ Never
- ❑ 1-4 times a year
- ❑ Once a month
- ❑ More than once a month

Have you ever had an aesthetic (cosmetic) surgery procedure? Yes / No

If so, please specify the type of procedure, surgeon, and date of procedure.

____

Select the areas or procedures that are of interest to you (please check all that apply):

- ❑ Face
- ❑ Eyes
- ❑ Nose
- ❑ Body Contouring
- ❑ Breast
- ❑ Other, please specify ____
- ❑ Not interested in a cosmetic procedure

When looking at my face, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

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ALLERGIES: Do you have any allergies to medications? ❑ No or ____

Injectables (Complete ONLY if here for injectable procedure)

Have you taken aspirin, anti-inflammatory medications (NSAIDs) or blood thinners (Coumadin, Warfarin, Lovenox, etc) within the past two weeks?	❑ Yes	❑ No
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
[For Women ONLY] Have you ever had heavy menses characterized by the presence of clots and/or changing a pad or tampon more than hourly, or resulting in anemia or low iron level?	❑ Yes	❑ No

Botox (Complete ONLY if here for Botox procedure)

Do you have any neuromuscular disorders (myasthenia gravis, Lambert-Eaton syndrome)?	❑ Yes	❑ No
[For Women ONLY] Is there a chance that you could be pregnant?	❑ Yes	❑ No
[For Women ONLY] Are you currently breast feeding?	❑ Yes	❑ No

Chemical Peels/Lasers (Complete ONLY if here for chemical peel or laser procedure)

Have you ever had a chemical peel or laser treatment to the face?	❑ Yes	❑ No
If yes, Type: __________________ Date: _______________________		
Have you ever had **HYPO**pigmentation (***loss of color***) as a result of the treatment?	❑ Yes	❑ No
Have you ever had **HYPER**pigmentation (***increase in color***) as a result of the treatment?	❑ Yes	❑ No
Have you ever had “fever or lip blisters” as a result of treatment around your lips?	❑ Yes	❑ No
Have you ever taken **antiviral** medications (before or after) treatment around your lips?	❑ Yes	❑ No

Sun Exposure (Complete ONLY if here for chemical peel or laser procedure)

How would you rate your daily **sun-exposure**? (Check **ONLY** one)

- ❑ Outdoors constantly under the sun
- ❑ Outdoors more often than not
- ❑ Outside occasionally, mainly inside
- ❑ Inside most of the time, rarely see the sun

How would you rate your daily **sun-protection** regimen? (Check **ONLY** one)

- ❑ Sun protection everyday, always try to shield myself from the sun
- ❑ Sun protection everyday, but don’t mind being out in the sun
- ❑ Sun protection occasionally
- ❑ Rare or never wear sun protection

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