Jeffrey D. Hoefflin, M.D., F.A.C.S
Board-Certified Plastic Surgeon
Diplomate, American Board of Plastic Surgery

9201 Sunset Blvd., Suite 805
West Hollywood, CA 90069
t 310.858.9105 f 310.858.9101
www.doctorhoefflin.com; jeff@drhoefflin.com

PATIENT INFORMATION

Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____
Last First MI

Sex: [ ] Male [ ] Female Marital Status: [ ] M [ ] S [ ] D [ ] W

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (___) ____-____ Cell Phone: (___) ____-____

E-mail Address: _____

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: (___) ____-____

City: _____ State: _____ Zip: _____

Responsible Party: [ ] Myself [ ] Other

If other, give name and address: _____

Who referred you to Dr. Hoefflin? _____

Why are you consulting Dr. Hoefflin? _____

_____

What possible surgery do you desire? _____

List any previous plastic surgery (include dates): _____

_____

MEDICAL HISTORY

Please carefully read and answer all questions. Your medical history is very important to the doctor for your proper medical care. This is a confidential record and will not be released without your permission.

Family Physician: _____ Telephone Number: (____) ____--_____

Date of your last complete physical examination: _____
Did it include the following? [ ] EKG [ ] X-ray [ ] Lab [ ] Other: _____
Current Height: _____ft.____in. Weight: _____lbs. Desired Weight: ____lbs.
How much do you smoke per day? _____packs. How much do you drink? _____
Are you allergic to any of the following?

1. Medications: _____
2. Foods: _____
3. Other: _____

Please list any and all medications you are taking:

1. Prescription Medications: _____
   _____
2. Non-prescription Medications (including vitamins, aspirins, etc.): _____
   _____

Do you have, or have you ever had any of the following:

[ ] Skin Cancer
[ ] Chronic Skin Infections
[ ] Sores That Do Not Heal
[ ] Diabetes
[ ] Keloids or Bad Scars
[ ] Hepatitis/HIV
[ ] Blood Transfusion/Last 10 Years
[ ] Jaundice
[ ] Heart Attack
[ ] Stroke
[ ] Heart Palpitations
[ ] Heart Murmur
[ ] High Blood Pressure
[ ] Mitral Valve Prolapse
[ ] Legs Clots or Embolus
[ ] Ankle Swelling
[ ] Poor Leg Circulation
[ ] Blood Clots In Legs
[ ] Easy Bleeding/Bruising

[ ] Glasses
[ ] Contact Lenses
[ ] Regular Eye Drop
[ ] Dry Eyes
[ ] Visual Difficulty
[ ] Hearing Difficulty
[ ] Arthritis
[ ] Anemia
[ ] Asthma
[ ] Frequent Cough
[ ] Herpes or Cold Sores
[ ] Chronic Sore Throat
[ ] Urinary Tract Infections
[ ] Severe Neck/Back Problems
[ ] Thyroid Problems
[ ] Rheumatic or Scarlet Fever
[ ] Migrane or Headaches
[ ] Stomach ulcers or Heartburn
[ ] Intestinal Bleeding/Ulcers
[ ] Hemorrhoids

[ ] Easy Fainting
[ ] Seizures
[ ] Excessive Anxiet
[ ] Excessive Depression
[ ] Excessive Fatigue
[ ] Suicidal Thoughts
[ ] Psychiatric Care
[ ] Eating Problems
[ ] Difficulty With Anesthesia
[ ] Nausea After Surgery
[ ] Unexpected Social Status
[ ] Abnormal Lab Tests:
[ ] Low Pain Tolerance

Are you taking any of the following?

[ ] Antibiotics
[ ] Diet Pills
[ ] Aspirin, Motrin, NSAIDS, or Cortisone
[ ] Blood pressure or Heart Medicine or Water Pill use
[ ] Birth Control Pills
[ ] Other Recreational Drug Use

[ ] Blood Thinners
[ ] Steroids
[ ] Metformin, Glucophage, or Insulin
[ ] Herbal Supplements
[ ] Hormone Supplements