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Plastic and Reconstructive Surgery
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PATIENT INFORMATION

Name: _____ Age: _____
Last **First** **MI**

Today's Date: ____/____/____ SSC#: _____-____-_____ Date of Birth: ____/____/____

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

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: **(** **)** **-** Cell Phone: **(** **)** **-**

E-mail Address: _____

Employer: _____ Occupation: _____

Business Address: _____ Phone: **(** **)** **-**

City: _____ State: _____ Zip: _____

Responsible Party: [ ] Myself [ ] Other

If other, give name and address: _____

Who referred you to 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: _____ Phone: (____) ____-____

Date of your last complete physical examination: ____/____/____

Did it include the following? [ ] EKG [ ] X-ray [ ] Lab [ ] Other: _____

Current Height: _____ft. _____in. Current Weight: _____lbs. Desired Weight: _____lbs.

How much do you smoke per day? _____ packs How much do you drink? _____

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
[ ] Thyroid Problems
[ ] Severe Neck/Back Problems
[ ] Rheumatic or Scarlet Fever
[ ] Migraine or Headaches
[ ] Stomach ulcers or Heartburn
[ ] Intestinal Bleeding/Ulcers
[ ] Hemorrhoids
[ ] Seizures
[ ] Excessive Anxiety
[ ] 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
[ ] Easy Fainting

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

Are you allergic to any of the following? (List any that apply)

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

Please list any and all medications you are taking: (List any that apply)

1. **Prescription Medications**: _____

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

   _____

Patient Signature: _____ **Date:** ____/____/____

SKIN CONCERNS

Please check all the categories you may be interested in treating:

[ ] Acne
[ ] Acne Scarring
[ ] Aging Skin
[ ] Broken Capillaries / Blood Vessels
[ ] Cellulite
[ ] Chest / Décolletage Rejuvenation
[ ] Crow's Feet (Eyes)
[ ] Dry Skin
[ ] Eyebrow / Eyelash Treatments
[ ] Excessive Underarm Sweat / MiraDry
[ ] Facial Veins
[ ] Fat Reduction
[ ] Fine Lines
[ ] Forehead Creases
[ ] Freckles
[ ] Frown Lines
[ ] Hair Removal
[ ] Hand Rejuvenation
[ ] Leg Veins / Spider Veins
[ ] Lip Volumizing
[ ] Mole Removal
[ ] Neck Rejuvenation
[ ] Oily Skin
[ ] Permanent Makeup
[ ] Pore Size
[ ] Restoration of Facial Volume
[ ] Rosacea / Redness
[ ] Scarring
[ ] Skin Care Products
[ ] Skin Rejuvenation
[ ] Skin Resurfacing
[ ] Skin Tag Removal
[ ] Skin Tightening
[ ] Smile Lines
[ ] Stretch Marks
[ ] Sun Damage / Brown Spots
[ ] Texture Improvement
[ ] Under eye Issues
[ ] Wrinkle Elimination

Other Interests: _____

_____

_____

Notes: _____

_____

_____

REFERRAL INFORMATION

Please let us know how you first heard about Dr. Hoefflin. (Please check one)

[ ] One of our patients: _____

[ ] Friend: _____

[ ] Another Doctor: _____

[ ] Online Search Engine(s) (i.e. Google or Yahoo): _____

[ ] Online: other site(s) (Please List): _____

[ ] Television: _____

[ ] Interview: _____

[ ] Other (Please Explain): _____

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California

(800) 633-2322

www.mbc.ca.gov

I acknowledge the above notice and understand that the physician is licensed and regulated by the board.

Patient Signature: _____ **Date:** ____/____/____