Nelson
Aesthetics & Cosmetics
JAMES C. NELSON JR. MD | COSMETIC SURGEON

PATIENT INFORMATION

DATE _____

FULL NAME _____ SEX _____ AGE ____ BIRTHDATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

Marital Status ___ Single (never been married) ___ Married ___ Divorced ___ Widowed

Home Phone # _____ Cell Phone # _____

Social Security # ___-___-_____ Email Address _____

Employer _____ Occupation _____

Address _____ Work Phone # _____

City _____ State _____ Zip Code _____

Spouse's Name _____ Spouse's Employer _____ Occupation _____

Address _____ City _____ State _____ Zip Code _____

Children's Names & Ages _____

Any family treated here before? _____ If Yes, name/relationship/approx. date _____

Closest local relative or friend not living with you _____

Address _____ Phone # _____

If patient is a minor, please complete this section:

Father's Name _____ Employer _____ Phone # _____
Mother's Name _____ Employer _____ Phone # _____

Person Responsible for Bill (if other than the patient)

Name _____ Relationship to Patient _____
Address _____ City _____ State _____ ZipCode _____
Employer _____ Phone # _____
Address _____ City _____ State _____ ZipCode _____

REFERRAL SOURCE

Friend (Specify) _____
Yellow Pages (Specify) _____
TV or Radio Ad (Specify) _____
Internet _____
Physician (Specify) _____
Seminar _____
Other _____

PERSONAL HISTORY

The requested personal information is necessary part of our evaluation. All information given to us is confidential.

Please list any problems or previous hospitalizations _____

_____

Have you had any serious past illnesses? _____

Please list any accidents or injuries _____

Please list any past surgeries (including minor surgery or surgery as a child) _____

_____

YES	NO	
_____	_____	Do you have any allergies to medications? List medications. _____
		_____
_____	_____	Do you have any food, environmental, latex allergies? List reactions. _____
		_____
_____	_____	Are you currently taking any drugs or medications? How often? List (include over the counter)
		_____
_____	_____	Do you take vitamins/herbal products? List. _____
_____	_____	Do you drink more than 6 cups of coffee a day?
_____	_____	Do you drink alcohol? How much? How often? _____
_____	_____	Do you smoke? How much? _____
_____	_____	Do you ever get cold sores or fever blisters?
_____	_____	Do you have skin sensitivities, frequent rashes, or eczema?
_____	_____	Have you ever taken Acutane?
_____	_____	Do you have a skin care regimen you follow? Describe _____
_____	_____	Have you ever received local anesthesia? (Novacaine)
_____	_____	Did you have a reaction to anesthesia?
_____	_____	Are you a past/present carrier of a contagious disease? Please specify _____
_____	_____	Are you or could you be pregnant?
_____	_____	Have you taken medicine such as Cortisone or steroud during the past year?
_____	_____	Do you have a personal or a family history of any bleeding or clotting abnormalities?
_____	_____	Do you bleed for more than a half hour after a needle stick?
_____	_____	Do you bleed a day or more after surgery or a tooth extraction?
_____	_____	Do you bruise easily?
_____	_____	Do you bruise without cause?
_____	_____	Do you bruise larger than a half dollar?
_____	_____	Do you bruise from injections?

Date of last physical _____ Date of most recent blood work _____

Date of last chest x-ray _____ Have you had an abnormal chest x-ray? _____

Have you ever had an abnormal EKG? _____

Family Physician _____ Family Physician Phone # _____

Physician Specialty _____

PERSONAL HISTORY

Height _____ Weight _____

DO YOU HAVE OR HAVE YOU EVER HAD: (Please check **ALL** that apply)

YES	NO		YES	NO	
_____	_____	Heart disease or heart trouble	_____	_____	High blood pressure
_____	_____	Lung disease	_____	_____	Liver disease
_____	_____	Kidney disease	_____	_____	Hay fever
_____	_____	Epilepsy/seizures/neurological problems	_____	_____	Chest pain
_____	_____	Thyroid or goiter problems	_____	_____	Chronic cough
_____	_____	Recent respiratory infection	_____	_____	Glaucoma
_____	_____	Skin trouble/infection/rashes/irritations	_____	_____	Phlebitis
_____	_____	Keloid or ugly scars	_____	_____	Fainting
_____	_____	Problems lying flat	_____	_____	Asthma
_____	_____	Nosebleeds	_____	_____	Diabetes
_____	_____	Jaundice	_____	_____	Anemia
_____	_____	Drug or alcohol dependency	_____	_____	Mitral valve collapse
_____	_____	Headache or dizzy spells	_____	_____	Difficulty urinating
_____	_____	Muscle weakness	_____	_____	Hiatal hernia
_____	_____	Ankle swelling	_____	_____	Blood transfusion
_____	_____	Facial fractures	_____	_____	Shortness of breath
_____	_____	Back or neck trouble	_____	_____	Ulcers/stomach trouble
_____	_____	Bowel/colon disease or problems			
_____	_____	Do you see eye drops?			
_____	_____	Treatment of genital area			
_____	_____	Are you easily depressed?			
_____	_____	Are you on a special diet?			
_____	_____	Recent weight loss (amount) _____			
_____	_____	Any exposure to a communicable disease in the last 3 weeks? Explain _____			
		_____			
_____	_____	Have you ever considered a psychologist/therapist?			
_____	_____	Are you seeing a therapist now?			

Do you have any of the following: (Please check **ALL** that apply)

_____ Dentures _____ Partial Plate _____ Bridgework _____ Contacts _____ Hearing aids

Family History: _____ Diabetes _____ Bleeding _____ Heart disease _____ Anesthesia problems _____ Other

Is there anything else you would like us to know?

_____

_____

_____

IN WHICH PROCEDURES ARE YOU INTERESTED

_____ Rhinoplasty
_____ Septoplasty (Correct trouble breathing)
_____ Face/Neck Lift
_____ Eyelid surgery
_____ Forehead surgery
_____ Endoscopic or minimal incision surgery
_____ Breast surgery (Augmentation)
  _____ Breast uplift
  _____ Breast reduction
  _____ Nipple surgery
_____ Abdominoplasty (tummy tuck)
_____ Liposuction
  _____ Stomach
  _____ Thighs
  _____ Hips
  _____ Ankles
  _____ Knees
  _____ Face

_____ Removal of facial lesions
_____ Scar revision
_____ Laser skin resurfacing
_____ Lip enlargement
_____ Lip reduction
_____ Chemical peel
_____ Removal of prominent veins on face
_____ Dermabrasion
_____ Facial Fillers
_____ BOTOX
_____ Fat Transfer
_____ Lines around lips
_____ Lines around eyes
_____ Skin Pigmentation
_____ Chin enlargement
_____ Chin reduction
_____ Other

What specifically do you wish to have changed? _____

_____

When did you begin to consider surgery correction? _____

Have you consulted with any other doctors about this? (When) _____

Have you discussed this surgery with your family? ____YES ____NO Are they agreeable? ____YES ____NO

Have you had a previous cosmetic surgery? ____YES ____NO

When was the surgery performed? _____
By Whom? _____

Were you satisfied with the result? _____
If not, why? _____

_____

Have you had any surgery or injury to the area?_____
Describe what and when _____

_____

Has anyone in your family or a close friend had cosmetic or reconstructive surgery?_____
If so, what was done?_____ By whom? _____