Richard D. Zeph, M.D., F.A.C.S.
Facial Plastic and Reconstructive Surgery
13590-B N Meridian Street, Suite 201 Carmel, IN 46032
(317) 573-7887 (800) 352-1056

MEDICAL QUESTIONNAIRE COSMETIC

Name_____Birthdate_____ Date_____

Address: Home_____(_____)_____
Street City State Zip Phone
Business_____(_____)_____
Street City State Zip Phone

Occupation_____Marital Status: S, M, D, W, Separated

Spouse's Name_____ Ages of Children_____

Email Address: _____Cell Number:(_____)_____

(REQUIRED) Pharmacy _____

Address_____Phone (_____)_____
Are you interested in aesthetician services? YES NO If so, what service?_____

How were you referred to us? _____

What are you being seen for today?_____

_____
Have you consulted any other doctor about this? YES NO_____

Have you discussed this surgery with your family? YES NO Are they agreeable? YES NO
Have you had <u>any</u> previous cosmetic surgery? YES NO When, and what was done? _____

_____
Who performed the surgery? _____ Were you satisfied with results? YES NO

List any prior surgeries_____

_____
Were there any complications? _____

List any current drugs or medications and frequency:_____

_____
List any medications you are allergic to:

_____
When was your last physical examination? _____

Who is your family doctor? _____

Address_____Phone _____

OVER

NO YES Would you object to our contacting him/her in regard to any medical problem that might arise?

NO YES Have you ever received local anesthesia (Novocain or Xylocaine) by a dentist or doctor?
If so, any reaction? _____

Do you or any family members have: (Indicate who)

Heart Trouble_____Excessive bleeding tendencies_____
Tuberculosis_____High blood pressure_____
Excessive bruising_____Excessive scarring_____
Diabetes_____Thyroid problems_____
Psychiatric or "nerve" problems_____
Do you have any history of bleeding? _____
_____

NO YES Do you have hay fever, nasal allergies or asthma?_____
NO YES Do you have or have you had any problems with your eyes?_____
NO YES Do you have frequent pains in the chest?
NO YES Do you have any blood pressure problems?_____
NO YES Has a doctor ever said you had "heart trouble" or irregular heartbeat?
NO YES Do you have "stomach trouble" or ulcers?
NO YES Do you get short of breath easily?
NO YES Do you have or have you had chest or lung problems?
NO YES Have you ever had liver, gall bladder trouble or "yellow jaundice?" (Circle)
NO YES Do you have any kidney disease?_____
NO YES Do you or any family members suffer from arthritis?
NO YES Do you have frequent skin infections, irritations or rashes? (Circle)
NO YES Do you often have severe headaches or dizzy spells? (Circle)
NO YES Has any part of your body ever been paralyzed or numb?_____
NO YES Have you ever had a convulsion or seizure?
NO YES Are you at a high risk for AIDS?
NO YES Have you ever had cold sores or fever blisters?
NO YES Are you frequently sick or ill?
NO YES Do you worry about your health?
NO YES Were you ever treated for anemia or any problems with your blood?_____
NO YES Have you ever taken hormones or thyroid medication? (Circle)
NO YES Do you smoke? How many cigarettes per day? _____
NO YES Do you drink more that 6 cups of coffee per day?
NO YES Do you usually take 2 or more alcoholic drinks a day?
NO YES Do you have Diabetes?
NO YES Do you often get depressed?
NO YES Are you considered a nervous person?
NO YES Have you ever received medical treatment for a "nervous condition"?
NO YES Have you ever been under the care of a psychiatrist or psychologist?_____
Do you have any other medical problems that have not been covered?
Explain_____
WOMEN ONLY: When was your last menstrual period? _____
NO YES Are your periods often irregular? NO YES If applicable, is there a possibility of pregnancy at this time?
NO YES Have you had "female" or GYN problems?_____
MEN ONLY:
NO YES Have you ever had prostate problems? _____

Signature of Patient_____Date_____