TEXAS SURGICAL ARTS

PATIENT INFORMATION Today's Date: ___________________

Name: ____Date of Birth: ______________Age: ________Sex: M F

Address____ ______________________________ ____________________

Street City, State Zip Code

Phone Number: _____________________Cell / Home E-mail: _________________________@___________________

Primary Care Physician: ________________________________Phone Number: ___________________________________

Pharmacy: _________________________ Ph: ________________Emergency Contact____________________________

Relationship to Patient: ___________________________________Phone: ______________________________________

Do you authorize Texas Surgical Arts to discuss your medical information with this person? Yes/No

How did you hear about Texas Surgical Arts? ____

What procedures or products are you interested in? (Check all that are applicable)

FACE	BREAST	BODY
__ Eyelid surgery	__Enlargement	__Liposuction
__ Botox	__Enlargement & Lift	__Tummy Tuck
__ Juvaderm	__Reduction	__Mommy Makeover
__ Restylane	__Reduction & Lift	__Buttock Augmentation
__ Voluma	__Revision	__Body Lift
__ Lip Enhancement	__Asymmetry	__Thigh Lift
	__Male Breast (Gynecomastia)	__Arm Lift
		__Post Bariatric Body Contouring
Other (please specify)		

MEDICATIONS: (List all medications/supplements you are currently taking) **DRUG ALLERGIES:**

____ ________________________________

____ ________________________________

____ ________________________________

____ ________________________________

MEDICAL HISTORY (Check all that apply currently or have been diagnosed with in the past)

__Heart Attack/Heart Failure	__Sleep Apnea	__HIV Positive
__Diabetes Insulin / Non-Insulin	__Musculoskeletal or Autoimmune Disease	__Reflux/GERD
__High Blood Pressure	__Pulmonary Embolism	__Anxiety
__High Cholesterol	__Hepatitis B/ C	__Depression
__History of Stroke	__Cirrhosis of the Liver	__Pregnancy (how many) ___
__Blood Clots (i.e. Legs)	__Fatty Liver	__Kidney Disease
Other:		

PAST SURGICAL HISTORY: (*List all surgeries. If there is no history, indicate 'No Surgeries'*)

Year:	**Type of Surgery:**	**Complications:** (*If any*)

FAMILY HISTORY:

Disease	**Relationship to Patient:**
Cancer	
Diabetes	
Heart Disease	
Other (Please explain)	

HEALTH HABITS: (Please write N/A if doesn't apply)

Habit:	**How Much Per Day?**
Caffeine & Type	
Tobacco	
llegal Drugs	
Alcohol	

Have you ever had a blood transfusion?

No

Yes – *Approximate Date*: ___________________

REVIEW OF SYMPTOMS: (*Check all symptoms you currently have*)

General	***Gastrointestinal***	***Eye, Ear, Nose, Throat***	***Cardiovascular***	***Skin***
__Chills	__Rectal Bleeding	__Bleeding Gums	__Chills	__Hives
__Dizziness	__Constipation	__Double Vision	__Irregular Heart Beat	__Bruise Easily
__Fainting	__Diarrhea	__Earache Difficulties	__Blood Clots	__Itching
__Fever	__Nausea	__Hay Fever	__Chest Pain	__Change in moles
__Headache		__Hoarseness		__Sores that do not heal

Women Only:

Last Menstrual Period_________

Last Mammogram___________

To the best of my knowledge, the above information is complete and correct.

I understand it is my responsibility to inform my doctor if I ever have a change in health.

x____ _____________

Signature of Patient, Parent, Guardian or Personal Representative Date

____ ______________________

Printed Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient