CENTER FOR COSMETIC SURGERY

NAME: _____ SEX: _____ AGE: _____

TODAY'S DATE: _____DO YOU SMOKE OR USE OTHER NICOTINE PRODUCTS? : _____

MEDICATION ALLERGIES: _____

FOOD ALLERGIES:_____ LATEX ALLERGY/SENSITIVITY?_____

CARDIAC /HEART ISSUES? _____BREATHING ISSUES?_____

DIABETES? _____ SLEEP APNEA/ CPAP? _____ HEIGHT: _____ WEIGHT: _____ BMI: _____

PLEASE FILL-OUT THIS BOX ONLY

SCHEDULED DATE & TIME: _____

SURGICAL TIME ESTIMATE: _____

SURGERY REQUEST: AM PM

***IF IMPLANTS, NEED TO RE-SIZE? _____**
WHEN? _____ WHERE? _____ WHO? _____

TYPE(S) OF SURGERY/HOURS:

AFTERCARE? Y or N SCHEDULED? Y or N
FACILITY:_____

PRE-OP APPT:_____

_____

POST- OP APPT:
_____

OTHER APPTS:_____

PAL PEARL--Date given Kligmans/Initials:_____

ANESTHESIA: GENERAL ORAL LOCAL

Needs Medical Clearance? _____
DVT Risk Plan:_____
Needs EKG □
Needs Mammogram □

PATIENT REFERRAL: □ **OPINION/REVIEW CARD:** □ **PHOTO AUTH? Yes** □ **No** □

VECTRA: Yes □ **No** □ **Date: _____**

Pre-Operative Packet Sent: Date: _____

7/2014