EK PLASTIC SURGERY

CONSULTATION AND MEDICAL QUESTIONNAIRE, PART I

DEMOGRAPHIC INFORMATION

Today's Date:

Name:

Date of Birth: Age:

Email:

Social Security #:

Home Address:

City State Zip

Home Phone #:

Cell Phone #:

Work Phone #:

☐ Single ☐ Married ☐ Divorced

Spouse Name:

Spouse Phone #:

Emergency Contact:

Emergency Contact #:

Occupation:

Employer:

Insurance Company:

Phone #:

Policy #: Subscriber #:

HOW DID YOU HEAR ABOUT DR. KOHAN?

(PLEASE CIRCLE ALL THAT APPLY)

Friend Patient Family Member

If so, Name: _____

May we thank them? ☐ Yes ☐ No

Google / Yahoo 1-800 My Surgeon Paper / Ad

www.EmilMD.com Facebook Instagram

Other (Specify): _____

WHICH PROCEDURES ARE YOU INTERESTED IN?

☐ **BREAST ENHANCEMENT**
(Breast Augmentation, Breast Lift, or Breast Reduction)

☐ **TUMMY TUCK / ABDOMINOPLASTY**
(Removal of excess skin and fat of the abdomen)

☐ **LIPOSUCTION / LIPOSCULPTURE**
(Minimally invasive removal of localized fat deposits)

☐ **MALE BREAST REDUCTION / GYNECOMASTIA**
(Removal of excess fat and breast tissue from the chest)

☐ **FACE LIFT / NECK LIFT / MIDFACE LIFT**
(Tightening of skin and muscles of the face and neck)

☐ **EYELID LIFT**
(Removal of excess skin and fat from the eyes)

☐ **EYEBROW / FOREHEAD LIFT**
(Lifting of the eyebrow through minimal incisions)

☐ **RHINOPLASTY / SEPTOPLASTY**
(Reshaping and straightening of the nose to improve breathing)

☐ **FACIAL IMPLANTS**
(Augmentation of the chin or cheek with implants)

☐ **ARM LIFT**
(Removal of excess skin and fat of the arms)

☐ **THIGH LIFT**
(Removal of excess skin and fat of the thighs)

☐ **BUTTOCK AUGMENTATION**
(Enhancement of the buttocks with implants or fat)

☐ **BOTOX®**
(To soften the wrinkles around the eyes and forehead)

☐ **RESTYLANE® / JUVÉDERM® / RADIESSE®**
(Fillers to improve the deeper wrinkles of the face)

☐ **PHOTOFACIAL**
(A laser treatment to improve redness and pigmentation of the face)

☐ **LASER HAIR REMOVAL**
(A laser treatment to reduce or eliminate unwanted hair)

☐ **LASER RESURFACING / CHEMICAL PEEL**
(A laser treatment to smooth out facial wrinkles and acne scarring)

☐ **OBAGI SKIN CARE / NIA SKIN CARE**
(A skin care system to help blemishes, acne, and large pores)

☐ **SCAR REVISION**
(Surgical improvement of unsightly appearing scars)

☐ **OTHER** (Please specify): _____

WHEN DO YOU WISH TO HAVE YOUR PROCEDURE?

☐ ASAP ☐ Within 1 month ☐ 1-3 months ☐ Not Sure

AUTHORIZATION / ASSIGNMENT: I understand that I am financially responsible for all charges, whether or not covered by my insurance company. Furthermore, I permit payment directly to Emil Kohan M.D. INC. for any benefits due or services rendered.

MEDICAL RECORDS: Authorization is hereby granted for release of any information required to process this claim. A copy of this authorization is as valid as the original. Authorization is hereby granted for release of pertinent information (this may include photographs, operative notes, clinic and consultation notes) to a hospital / another physician's office for appropriate continuum of care treatment as required.

PRIVACY POLICY: I acknowledge I have received / have been offered a copy of Emil Kohan M.D. Inc. notice of privacy practices.

Signature: _____

Date: _____

PLASTIC SURGERY

CONSULTATION AND MEDICAL QUESTIONNAIRE, PART II

MEDICAL HISTORY

Height: Weight:

Family Physician:

Address / Phone Number:

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

(PLEASE CIRCLE ALL THAT APPLY)

Headaches	Strokes
Seizures	Fainting Spells
Heart Disease	High Blood Pressure
Chest Pain	Shortness of Breath
Lung Disease	Thyroid Disease
Liver Disease / Hepatitis	Ulcers
Anemia	Bleeding Problems
HIV	Blood Clots
Family / Personal history of problems with Anesthesia	

Do you have any other medical problems / conditions? (Please list below)

Have you ever had surgery before? (Please list below)

Type **Date**

List any medications you take on a regular basis (Including appetite suppressants, vitamins, herbal supplements, or any homeopathic medication)

Name **Dosage**

Do you have any allergies to medications?

Name **Reaction**

SOCIAL HABITS

Cigarette Smoking: ☐ Yes ☐ No # of cigarettes / day: ___

Alcohol Use: ☐ Yes ☐ No # drinks / week: ___

Drug Use: ☐ Yes ☐ No

FOR WOMEN ONLY

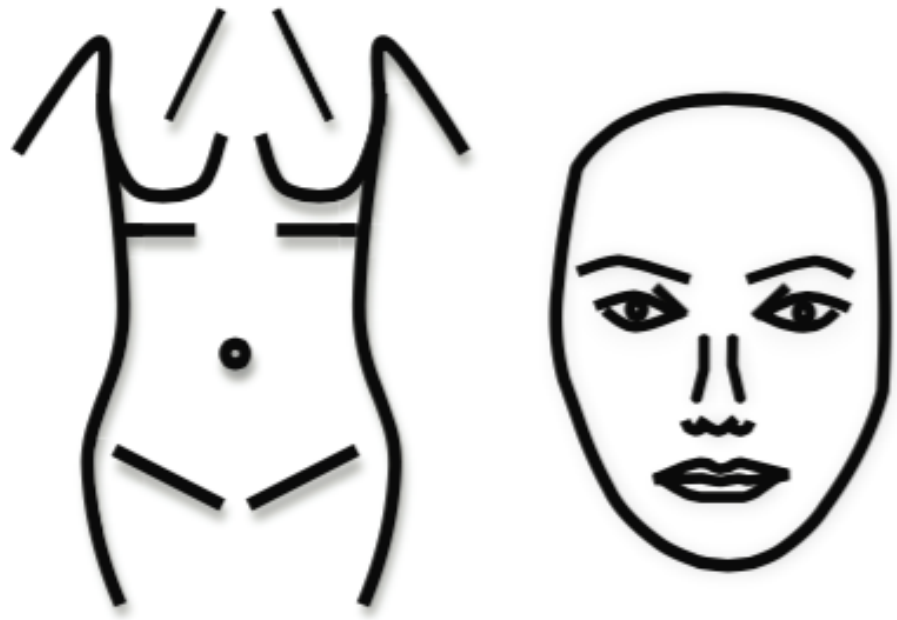
of pregnancies: # of live births:

Did you breast feed? ☐ Yes ☐ No

Do you have any family / personal history of breast cancer? ☐ Yes ☐ No

Date of last mammogram: Results:

DOCTOR'S NOTES



Surgical Procedure(s) / Plan **Time (hrs)**

1.

2.

3.

4.