Patient History Form

Center for Facial and Body Rejuvenation
Elbert T. Cheng M.D. and Jacqueline T. Cheng M.D.
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Patient Name:_____
Last First MI
Date of Birth: _____ Age _____ Height: _____Weight:_____ BMI: _____

Reason(s) for seeing physician: _____

What are your esthetic concerns?

___Rhinoplasty (nose surgery)	___Forehead Lift	___Removal of moles or lesions	____Facial Veins
___Eyelids	___Face or Neck Lift	___Botox/Injectable filler	____Lines / Wrinkles
___Chin	___Scar Revision	___Repair of torn earlobe	____Freckles / Age Spots
___Protruding Ears	___Skin Resurfacing	___Laser Hair Removal	____Acne / Acne Scars
___Liposuction	___Thinning or Lack of Eyelashes	___Hair Transplantation	____Skin Care Advice
___Fat Removal on the Body	___Skin Tightening	___Eyelash Enhancement	____ Cellulite

Other:_____ _____

Have you consulted another doctor in regards to this type of surgical procedure?_____
If so whom?_____
Please list **all medications, vitamins, or supplements** you are currently taking (including birth control, hormones and natural dietary supplements):_____
_____
Previous surgeries (including cosmetic):_____
_____
Describe any complications you may have experienced:_____
_____
Any known allergies?__Yes __No Please list:_____
Are you allergic to latex gloves? ___Yes ___No
Have you taken steroid within the past year? ___Yes ___No
Do you take aspirin and/or baby aspirin, regularly? __Yes __ No
_____

Family doctor / Internist: _____Address: _____
OB/Gyn? _____Address: _____
Date of last physical exam: _____May we notify him/her of your upcoming surgery?
_____
If you are currently being treated by a psychiatrist or psychologist:
Name: _____ Phone number _____
_____

Have any family members been affected by any of the following conditions?

____Heart Disease	____Poor Healing	____Excessive Bleeding
____High Blood Pressure	____Thyroid Disease	____Psychiatric or "nerve" problems
____Diabetes	____Reactions or complications to anesthesia	

_____

Have you ever had any reaction to local or general anesthesia? ____Yes ____No If yes, please describe:
_____

Ever taken Accutane?	**__Yes ___No**	**If stopped, when? _____**
Caffeinated drinks:	**__Yes ___No**	**# per day _____**
Tobacco use:	**__Yes ___No**	**# packs a day____ If stopped, when?_____**
Use nicotine patch?	__Yes ___No	Does anyone in your household smoke? __Yes __No
Drink Alcohol?	**__Yes ___No**	**How many a day? _____**
Use Recreational drugs	**__Yes ___No**	**If so, what? _____**

Have you been told to take antibiotics prior to getting your teeth cleaned by the dentist? ___Yes ___No

Have you ever been treated or diagnosed with any of the following? Mark all that apply.

____ Rheumatic heart disease	____ Cold sores / Fever blisters	____ Stroke
____ High blood pressure	____ Heart murmur	____ Angina / Chest pain
____ Heart attack	____ Hay fever / Nasal allergies	____ Lung / Chest problems
____ Hepatitis / Jaundice	____ Anemia	____ Asthma
Type: A __ B __ C __	____ Ulcers	____ Lupus / Scleroderma
____ HIV / (AIDS)	____ Cancer	____ Depression
____ Psychiatric problems	____ Staph infections	____ Seizures / Convulsion
____ Bleeding tendencies	____ Easy bruising	____ Diabetes
____ Excessive scarring	____Latex allergy	____Alcohol / Drug dependency
____ Any eye problems	____ Skin condition, infection, irritation	____Thyroid problems

Other: _____

Do you have any other medical problems that have **not** been covered?_____
If so please explain:_____

Do you realize that every operation is followed by a period of healing before the tissue returns to normal and a final result is apparent?
___Yes___No

Do you understand that the objective of any cosmetic surgery is improvement in appearance, ***not perfection***? ___Yes ___No

Female Patient Only:

Are you pregnant? ___Yes ___No
Date of last menstrual period: _____
Number of past pregnancies: _____
Number of live births: _____

Please list any other additional information you think is or would be important for us to know about your medical or social history prior to your surgery. Do you have any specific or unique questions you want answered?

_____
_____
_____

Confidential Record*: Information contained here* ***will not be released*** *unless you have authorized us to do so.*
Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in making decisions regarding your care.
I authorize my physician and/or administrative and clinical staff to telephone or otherwise contact me (or the responsible party) regarding appointments, treatment information, or any other details related to patient therapy and treatment.

Signed: _____ Date: _____

Public Statements Agreement:

Center for Facial and Body Rejuvenation, Dr. Elbert Cheng, Dr. Jacqueline Cheng (hereinafter collectively "Physician") and I (hereinafter collectively "Patient") agree to:

1. Patient exclusively and permanently assigns all property rights and copyrights to Physician for any statement created by Patient that relates in any way to Physician;
2. Physician shall provide professional services to Patient; and
3. Patient's assignment set forth above (#1) shall be valid for five (5) years from the last date of service by Physician to Patient.

Patient acknowledges that he/she has had ample time to review this Public Statements Agreement. Further, Patient understands that nothing in this Public Statements Agreement prevents Patient from making a statement about Physician. Statements can be either written or electronic.

_____ _____ _____
Physician Patient Date

_____ _____
Witness Date