GENERAL INFORMATION:

Patient Name: Date of Birth:

Referring Physician or Patient:

How did you hear about Dr. Wagner?

Have you been to our website [www.wagnerplasticsurgery.com]? Yes No

If yes, was our website helpful? Yes No

If No, please list reason:

Have you consulted with other physicians about procedure(s) indicated above? Yes No

If No, please list reason:

Is this procedure a revision from a previous surgery? Yes No

If Yes, how many previous surgeries?

What is your time preference for your procedure(s)? Within 1 Month Within 3 Months

Within 6 Months Within 12 Months

PROCEDURE INFORMATION

What is the reason for your visit today? [Check all applicable procedures below]

FACE	BREAST	BODY	SKIN
☐ Brow Lift	☐ Breast Augmentation	☐ Liposuction	☐ Botox Cosmetic
☐ CO2 Laser	☐ Breast Lift (Mastopexy)	☐ Tummy Tuck	☐ Juvederm (Lip Volume, Laugh Lines)
☐ Kybella	☐ Breast Revision/Repair	☐ Mommy Makeover	☐ Vollure (Lip Volume, Shallow Laugh Lines)
☐ Liquid Facelift	☐ Breast Implant Exchange	☐ Body Lift	☐ Vobella (Lip Line Softening, Light Lip Volume)
☐ Lower Eyelid Lift	☐ Breast Capsulectomy	☐ Brazilian Buttlift (Fat Transfer)	☐ Voluma (Defined Cheeks)
☐ Neck Lift	☐ Breast Reduction	☐ Arm Lift	☐ Kybella
☐ Rhinoplasty	☐ Breast Assymetry	☐ Thigh Lift	☐ CO2 Laser
☐ Scar Revision	☐ Male Breast Reduction (Gynecomastia)	☐ Coolsculpting	OTHER:
☐ Upper Eyelid Lift	OTHER:	OTHER:	
OTHER:			

REVIEW OF SYSTEMS

Please change the answer to **Y** if you are experiencing or suffer from any of the following:

GENERAL	**Y**	**N**	**SKIN**	**Y**	**N**	**EYES**	**Y**	**N**
Fatigue			Change in Mole Appearance			Blindness		
Fever			Hair Loss			Cataracts		
Sweats			Itching			Glaucoma		
Generalized Weakness			Rash			Vision Changes		
ADDITIONAL COMMENTS:			*ADDITIONAL COMMENTS:*			*ADDITIONAL COMMENTS:*		

GENITOURINARY	**Y**	**N**	**MUSCULOSKELETAL**	**Y**	**N**	**PSYCHIATRIC**	**Y**	**N**
Painful Urination			Arthritis			Anxiety		
Blood in Urine			Artificial Joints			Bipolar Disorder		
Kidney Failure/Dialysis			Fibromyalgia			Depression		
Kidney Stones			Joint Pain / Stiffness			Suicidal Thoughts		
'Incontinence			Muscle Cramping			Schizophrenia		
Urinary Tract Infections			Swelling of Joints					
ADDITIONAL COMMENTS:			*ADDITIONAL COMMENTS:*			*ADDITIONAL COMMENTS:*		

HEART	**Y**	**N**	**NEUROLOGICAL**	**Y**	**N**	**GASTROINTESTINAL**	**Y**	**N**
Arrhythmia			Episodes of Vision Loss			Abdominal Pain		
Atrial Fibrillation			Headaches			Black, Tarry Stools		
Chest Pain			Memory Loss			Blood in Stools		
Congestive Heart Failure			Migraines			Constipation		
Fainting Episodes			Multiple Sclerosis			Diarrhea		
Heart Attack			Numbness/Tingling			Heartburn		
Heart Murmur			Paralysis			Hemorrhoids		
Hypertension			Parkinson's Disease			Irritable Bowel Syndrome		
Pacemaker *(Please bring card)*			Seizure Disorder			Nausea or Vomiting		
Palpitations			Slurred Speech			Rectal Bleeding		
Stents			Stroke			Hiatal Hernia		
			Tremors					
HEART	**Y**	**N**	**NEUROLOGICAL**	**Y**	**N**	**GASTROINTESTINAL**	**Y**	**N**
(Continued)			*(Continued)*			*(Continued)*		

ADDITIONAL COMMENTS:			*ADDITIONAL COMMENTS:*			*ADDITIONAL COMMENTS:*		

EAR/NOSE/THROAT	**Y**	**N**	**LUNGS**	**Y**	**N**	**HEMATOLOGICAL**	**Y**	**N**
Dizziness			Chest Pain			Anemia		
Hoarseness			Cough			Blood Transfusions		
Nosebleeds			Coughing with Blood			Leukemia		
Ringing In Ears			History of Lung Nodules			Lymphadenopathy		
Runny Nose			History of Tuberculosis			Prone to Bleeding		
Sinus Infection			Shortness of Breath			Prone to Bruising		
Sore Throat			Sleep Apnea			Sickle Cell Disease		
			Wheezing					
ADDITIONAL COMMENTS:			*ADDITIONAL COMMENTS:*			*ADDITIONAL COMMENTS:*		

ARE YOU CURRENTLY PREGNANT? YES NO

FAMILY HISTORY

Please indicate if anyone in your family has been diagnosed with any of the following:

CONDITION / DISORDER	**NONE**	**MOTHER**	**FATHER**	**SIBLING**	**CHILD**	**GRDPARNT**

Bleeding Disorder						
Cancer (Non-Melanoma)						
Diabetes (Type I)						
Diabetes (Type II)						
Epilepsy						
Heart Disease						
Hypertension						
Glaucoma						
Kidney Disease						
Melanoma						
Stroke						
Thyroid Disease						

Additional Information (Optional):

SOCIAL HISTORY

What is your marital status?

Occupation:

Do you smoke cigarettes

How many packs per day?

For how long?

Do you smoke cigars?

How many per day/week?

For how long?

Do you drink alcoholic beverages?

How many per week?

PAST MEDICAL HISTORY

Please change the answer to **Y** if any of the following chronic medical conditions apply:

	Y	N		Y	N		Y	N
Allergies			Cirrhosis			Kidney Disease		
Alzheimer's Disease			Clotting Disorder			Lupus		
Anemia			COPD (Lung Disease)			Lymphoma		
Anxiety			Depression			Meningitis		
Arthritis			Diabetes Mellitus Type I			Myocardial Infraction		
Asthma			Diabetes Mellitus Type II			Nerve/Muscle Damage		
Blood Transfusion			Emphysema			Osteoporosis		
Breast Issues			GERD (Heartburn)			Polycythemia Vera		
Cataracts			Glaucoma			Polymyalgia Rheumatica		
Congestive Heart Failure			Heart Murmur			Rheumatoid Arthritis		
Cirrhosis			HIV / AIDS			OTHER:		
Chronic Bronchitis			Hypertension					

ADDITIONAL INFORMATION (Please list any past medical history not covered above or elaborate, if necessary):

SURGICAL HISTORY

DATE	SURGICAL PROCEDURE	UNDERLYING CONDITION

PHARMACY INFORMATION *(Required):*

What is the name of the pharmacy you would like us to utilize for prescriptions?

What is the address of the pharmacy you listed?

What is the pharmacy telephone number?

MEDICATIONS

Please list *all medications* you take, including *over-the-counter* (OTC) medications and *vitamins*. Include specific doses and when taken.

If you don't know, please call your pharmacist to confirm.

NAME OF MEDICATION	DOSAGE	DIRECTIONS