



Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Age: \_\_\_\_\_

**REASON FOR TODAY'S VISIT**

Cosmetic Surgery Consult \_\_\_\_\_

Skin Care Consult \_\_\_\_\_

Botox® \_\_\_\_\_

Dermal Filler Consult  
(Restylane, Juvederm, Artefill, Perlane, Radiesse) \_\_\_\_\_

Reconstructive Consult \_\_\_\_\_

Emergency Room Follow-up \_\_\_\_\_

Surgical Follow-up \_\_\_\_\_

Other \_\_\_\_\_

**HOW DID YOU HEAR ABOUT DR. MCCORMACK?**

Physician Referral \_\_\_\_\_

Physician Name: \_\_\_\_\_

Advertisement \_\_\_\_\_

Magazine: \_\_\_\_\_

Newspaper: \_\_\_\_\_

Website \_\_\_\_\_

Seminar or Event \_\_\_\_\_

Friend or Word of Mouth \_\_\_\_\_

Name (optional): \_\_\_\_\_



**PAST MEDICAL HISTORY**

Major Illness or Hospitalizations

Year: \_\_\_\_\_

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Previous Surgeries (please include elective cosmetic surgery)

Year: \_\_\_\_\_

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**FAMILY AND SOCIAL HISTORY**

Married: \_\_\_\_\_ Single: \_\_\_\_\_ Do You Live Alone? \_\_\_\_\_

Occupation: \_\_\_\_\_

Do You Exercise Regularly? \_\_\_\_\_



**PAST MEDICAL HISTORY CONTINUED**

Do You Smoke or Use Tobacco of any Kind? No \_\_\_\_\_ Yes \_\_\_\_\_

Do You Drink Alcohol? No \_\_\_\_\_ Yes \_\_\_\_\_

Daily: \_\_\_\_\_ 1-4 Times/week: \_\_\_\_\_

1-4 Times/month: \_\_\_\_\_ 1-4 Times/year: \_\_\_\_\_

**SYSTEMIC REVIEW**

Do you have a history of any of the following medical problems?

AIDS/HIV No \_\_\_\_\_ Yes \_\_\_\_\_

Arthritis No \_\_\_\_\_ Yes \_\_\_\_\_

Blackouts/Fainting No \_\_\_\_\_ Yes \_\_\_\_\_

Bladder/Urinary Tract No \_\_\_\_\_ Yes \_\_\_\_\_

Bleeding Problems No \_\_\_\_\_ Yes \_\_\_\_\_

Cancer No \_\_\_\_\_ Yes \_\_\_\_\_

Diabetes No \_\_\_\_\_ Yes \_\_\_\_\_

Digestive System  
(Stomach Ulcers, Heartburn, etc.) No \_\_\_\_\_ Yes \_\_\_\_\_

Ear, Nose, Throat  
(Hearing Loss, Sinus Problems, etc.) No \_\_\_\_\_ Yes \_\_\_\_\_

Eyes  
(Glaucoma, Cataracts, Dry Eyes, etc.) No \_\_\_\_\_ Yes \_\_\_\_\_

Heart  
(Capd, Murmur, Pacemaker, Irregular Heart Beat, Shortness Of Breath, etc.) No \_\_\_\_\_ Yes \_\_\_\_\_

Hepatitis No \_\_\_\_\_ Yes \_\_\_\_\_



**SYSTEMIC REVIEW CONTINUED**

High Blood Pressure	No _____ Yes _____
Lungs	No _____ Yes _____
Neurologic (Numbness, Weakness, Stroke, etc.)	No _____ Yes _____
Pregnancy	No _____ Yes _____
Psychiatric (Depression, Anxiety, etc.)	No _____ Yes _____
Skin Problems (Rashes, etc.)	No _____ Yes _____
Tuberculosis	No _____ Yes _____
Are You Currently Taking Coumadin?	No _____ Yes _____
Insulin?	No _____ Yes _____
Aspirin?	No _____ Yes _____
Ibuprofen?	No _____ Yes _____
Herbal Supplements ?	No _____ Yes _____

**CURRENT MEDICATIONS**

\_\_\_\_\_

**DO YOU HAVE ALLERGIC REACTIONS TO ANY MEDICATIONS?**

\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date \_\_\_\_\_