Welcome! And thank you for choosing Dr Boneti Plastic Surgery. We strive to provide your medical care in an optimal timeframe, a pleasant and professional setting, focused on a holistic approach of the problem. The decisions on how to treat a disease and whether or not to undergo reconstructive or cosmetic surgery is very important and our mission is to empower you with knowledge in order for us to decide together the best option for you and your case.

Typically as our patient you will meet with your surgeon at the initial consultation and then again approximately one week prior to any surgical procedure for a pre-operative visit. At that time we will review the proposed operation, expected outcomes, and possible complications. Although we hope to answer all of your questions during your visits, if there are additional concerns, please feel free to contact us between visits either by email or by telephone. We will do our best to respond as soon as possible. Occasionally we will set up an additional visit if necessary to ensure that you are completely informed and comfortable with your treatment plan.

After your surgery, revision (touch-ups) are occasionally necessary to achieve the best results. If this occurs, your surgeon might wave his fee, but you could be responsible for anesthesia and surgical facility fees.

Photographs are a necessary part of your plastic surgery medical record. They will be taken at your initial consultation, at follow-up visits, and occasionally during surgery. They will be used for both surgical planning and teaching purposes. Your confidentiality will be protected at all times.

I hereby grant permission for the use of my medical records including illustrations, photographs, or other imaging records created in my case, for use in examination, testing, credentialing and /or certifying purposes by The American Board of Plastic Surgery, inc.

________________________________________

Patient’s Name (PRINT) Date

________________________________________

Patient's Signature

____________________________________

Witness's Name

____________________________________

Witness's Signature

Please assist us in planning your care by filling out the following survey as completely as possible. Thank you.

Today's Date: ____________________

DEMOGRAPHICS:
Name: _____________________________________________________________________________

Prefix Last First Middle
How would you like to be addressed? ___________________________________________________
Address: ___________________________________________________________________________

Street City State Zip

Phone Numbers:

Home: __________________ Work: __________________ Cellular: ___________________ E-Mail Address: ________________________________________________________________________ Social Security Number: ______________________ Date of Birth: ___________________________ Gender: ___________________________________ Marital Status: __________________________ Emergency Contact Information:

Name: _________________________________________ Relationship: ___________________

Phone Numbers: ________________________________________________________________

Primary Care Physician: __________________________________ Phone Number: _________________
Who referred you? ______________________________________________________________________

MEDICAL HISTORY:
What is your primary reason for seeing the doctor today? _____________________________________

_____________________________________________________________________________________
_____________________________________________________________________________________

For how long have you had this problem or when did you first notice this problem? _________________
_____________________________________________________________________________________

Please list any medical problems that you have: ________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Please list all non-cosmetic surgical procedures that you have had (include dates if known): __________

__________________________________________________________________________________________

__________________________________________________________________________________________

Please list all cosmetic procedures you have had, including Botox and other injections (include dates if known): _________________________________________________________________________________

__________________________________________________________________________________________

Did you have any difficulty with the anesthesia? If so, explain. ___________________________________

__________________________________________________________________________________________

Please list all medications (including prescription, other-the-counter, vitamins, herbal supplements) you are currently taking: _____________________________________________________________________

__________________________________________________________________________________________
__________________________________________________________________________________________

Please list all ALLERGIES you have to any medications (with reactions): ___________________________
__________________________________________________________________________________________

Current Height: ____________ Current Weight: ____________ Maximum Adult Weight: ___________
When was the last time you saw your primary care physician? ___________________________________
Smoking History:

Do you currently smoke cigarettes? Yes / No
How many packs per day? ___________ When did you start smoking? _____________

Have you ever smoked cigarettes? Yes / No
When did you start smoking? _________ When did you stop smoking? _____________

Are you using nicotine patches or gum? Yes/No
Do you smoke pipes, cigars, or chew tobacco> Yes / No

Alcohol History:
Do you drink alcohol? Yes / No
How many alcoholic drinks do you consume in 1 week (1 beer + 1 drink)? ___________________

Please list any medical conditions that your family members have had (high blood pressure, diabetes, blood clots, cancer): ____________________________________________________________________

_____________________________________________________________________________________

Gynecologic History:
Number of pregnancies: _________ Vaginal deliveries: _______ Caesarian Sections: _______ Date of last menstrual period: _________________________
Have you ever taken oral contraceptives or estrogen? Yes / No
How many children do you have? ______ Please list their ages: __________________________

REVIEW OF SYSTEMS **(please circle all that currently apply):**

**General**
Weight changes
Easy bruising
Fatigue
Prolonged Bleeding
Fevers
Healing problems
Chills
Blood clots

**Infections**
HIV/AIDS
Hepatitis

**Skin**
Skin rashes
Skin cancer
New skin infections
Changing skin lesions
Recurrent cold sores

**Eyes**
Eye pain
Eye irritation Contact lenses
Excessive tearing
Visual Changes
Glaucoma
Double vision
Eye light sensitivity

**Nose/Sinus**
Prior nose surgery
Prior nose trauma
Sinus allergies
Nighttime snoring
Difficulty breathing through nose
Sleep apnea
Sinus Infections
Voice changes

**Mouth/Teeth**
Dental infection
Dental crowns/caps
Previous oral surgery
Oral cancer
Dental implants
Wear dentures

**Breast**
Breast mass
Nipple discharge
Prior breast biopsy
Fibrocystic breast disease

Heavy menses
Tender breasts

**Heart/Cardiovascular**
Irregular heart beat
Prior angiogram
Non-healing leg wounds
Previous blood transfusion

**Lungs/Pulmonary**
Asthma
COPD
Emphysema Bronchitis
Pneumonia
Shortness of breath
Tuberculosis (TB)
Persistent cough
Pulmonary embolism
Coughing up blood

**Stomach/Intestinal**
Stomach ulcer disease
Blood in stool
Stomach reflux
Black or tarry stool
Diarrhea
Hepatitis
Constipation
Cirrhosis
Urologic
Difficulty urinating
Incontinence
Persistent flank pain

**Ears**
Ear pain

**Musculoskeletal**
Join pain / arthritis Back pain
Bone pain
Neck pain
Leg cramping
Difficulty walking

**Heart/Cardiovascular**
High blood pressure
Pacemaker
Murmur
Heart attack
Prior heart surgery

**Neurologic**
Seizures
Headaches
Prior head injury
Stroke or TIA
Problems with balance
Dizzy spells
Migraine headaches
Tremors
Memory loss
Trouble concentrating

**Psychiatric**
Depression
Alcoholism
Drug use
Anxiety
Bipolar disease

**Endocrine**
Diabetes
Cold fingers or toes
Thyroid disorder
Heat intolerance
Cold intolerance

______________________________________________

The information I have given above is complete and accurate. As with all medical records, the information provided will be confidential.

Patient Signature: ____________________________________________________________________

Today's Date: ________________________________________________________________________