Santa Barbara Plastic Surgery Center

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Aesthetic Surgery Questionnaire

Name: _____ Date of birth: _____

Date form completed: _____

1. What is your primary reason for todays visit?

   _____

2. Who is your primary care doctor? NAME:_____ LOCATION:_____
3. Who referred you to us? NAME:_____ LOCATION:_____
4. Your referral was? ☐MD / ☐ relative / ☐friend / ☐ tv ad / ☐ internet/ ☐ self
5. Interest/concern/reason for today's visit:
   - ☐ Facial lines/wrinkles ☐ Thin/wrinkled lips ☐ Thin lashes_____☐ Facial contour
   - ☐ Breast issue:_____
   - ☐ Body issue: _____
   - ☐ Abdomen: _____
   - ☐ Other: _____
6. Have you previously used Botox®? ☐ Yes ☐ No : If yes, last injection date: _____
7. Have you previously used fillers (Juvederm®)? ☐ Yes ☐ No : If yes, last injection date: _____
   - Previous treatment area(s): _____
8. Have you previously had laser skin treatments? ☐ Yes ☐ No : If yes, date: _____
   - Previous treatment area(s): _____

❖ Have you ever had any of the following procedures?

	Yes	No
• Breast implants (still present)	☐	☐
• Blepharoplasty (eyelid surgery)	☐	☐
• facelift	☐	☐
• rhinoplasty (nose job)	☐	☐
• abdominoplasty (tummy tuck)	☐	☐
• liposuction	☐	☐
• other :_____		

❖ How is your overall heath? ☐Good ☐ Not good: _____

❖ Do you have any chronic medical conditions (diabetes, heart disease, hypertension, etc.)?

_____

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- What is your height? _____ ft _____in.
- What is your weight? _____lbs. How long has it been stable? _____
- Have you been hospitalized? ☐ Yes ☐ No: if yes, when and why?
- Do you bruise or bleed easily? ☐ Yes ☐ No
- Do you have glaucoma/eye pressure issue? ☐ Yes ☐ No
- Have you ever been diagnosed with a heart condition? ☐ Yes ☐ No
  - If yes, what condition/treatment?_____
- Do you smoke? Yes ☐ No ☐
  - If yes, how many cigarettes/day?_____packs/day?_____
  - Have you tried to quit? _____ what method did you use? _____
- Do you drink alcohol? Yes ☐ No ☐ If yes, how many drinks per week? _____
- Have you ever been diagnosed with depression? Yes ☐ No ☐ Other psychiatric conditions? ☐ Yes ☐ No If yes, what and when?_____
- **Current Medications (including vitamins/herbs, aspirin, over-the-counter medications)**

Name	Strength	Qty	Frequency	Start Date	Stop Date

- **Allergies, to medications, foods, etc. (including lidocaine, topical anesthetics)**

Substance	Reaction (e.g., itchy eyes, hives)

- **PAST SURGERIES:**

Additional notes:

_____
_____
_____
_____
_____
_____
_____