Santa Barbara Plastic Surgery Center

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Santa Barbara Plastic Surgery Center 427 West Pueblo Street, Suite A, Santa Barbara, CA 91326
Phone 805-687-7336 Fax 805-687-9491 www.sbplasticsurgery.com

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.)?

_____

❖ 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?

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- 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:

_____
_____
_____
_____
_____
_____
_____