MICHAEL J. BROWN, M.D., PLLC
Aesthetic Cosmetic Plastic Surgery

In order for our office to best prepare for your visit, please complete the information below and bring this form with you on the day of your consultation.

Your appointment is scheduled for_____ in_____ at_____ ❑ am ❑ pm

PATIENT INFORMATION

Confidential Information: The information herein will not be released except when you have authorized us to do so. This information will be used by the doctors in their decisions regarding your care.

Today's date: _____

Patient's Name: _____

Parent or Guardian's Name (for minors): _____

Address:_____

City: _____ State: _____ Zip:_____

Telephone Numbers: Home: _____ Cellular: _____ Work: _____

E-mail address: _____ please check: ❑ okay to use ❑ please do not use

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Social Security Number: _____

Emergency Contact Name: _____

Telephone: Home: _____ Cellular:_____ Work: _____

Employer (if patient is a minor, parent's place of employment): _____

Employer Address: _____ Telephone:_____

Referring Physician (or source of reference): _____

Physician Address: _____ Telephone:_____

Family Physician's Name:_____

Address: _____ Telephone:_____

Dermatologist's Name: _____

Address: _____ Telephone:_____

Your health is of extreme importance to us. The more we know about you, the better we can assist you. Please complete the information on the following pages as completely as possible.

What brings you to our office? Please be as specific as possible. _____

_____

_____

How long has this concerned you? _____

Have you had any previous treatment for this? _____

If YES, how and when was this treated? _____

Review of systems:

Do you have or have you had any of the following? *(Please check yes or no)*

	YES	NO		YES	NO
AIDS or HIV positive	❑	❑	Hepatitis	❑	❑
Anemia	❑	❑	High blood pressure	❑	❑
Arthritis	❑	❑	Irregular heart beat	❑	❑
Asthma	❑	❑	Kidney problems	❑	❑
Back problems	❑	❑	Migraine headaches	❑	❑
Blood clots in legs	❑	❑	Nervous breakdown	❑	❑
Blood disorders	❑	❑	Nose/throat problems	❑	❑
Bleeding problems	❑	❑	Pneumonia	❑	❑
Breathing problems	❑	❑	Psychiatric condition	❑	❑
Cancer	❑	❑	Rheumatic fever	❑	❑
Chest pains	❑	❑	Seizures	❑	❑
Colitis	❑	❑	Shortness of breath	❑	❑
Diabetes	❑	❑	Skin cancer	❑	❑
Ear/eye problems	❑	❑	Stomach problems	❑	❑
Epilepsy	❑	❑	Stroke	❑	❑
Heart problems	❑	❑	Thyroid problems	❑	❑
Heart murmur	❑	❑	Tuberculosis	❑	❑
Heart palpitations	❑	❑	Transfusion	❑	❑

Past, Family and/or Social History:

List any hospitalizations and/or previous surgery, including dates: _____

_____

_____

Are you allergic to or have you ever had a reaction to any medication or drug; local anesthetic; or general anesthetic? If so, please list medication and type of reaction: _____

_____

Are you now or have you ever taken any medications regularly (aspirin, birth control pills, herbs, vitamins, etc.)?

Currently taking: _____

_____

Previously taken: _____

Do you wear contact lenses? _____

Do you have problems with dry eyes? _____

Do you use wetting drops? _____

If so, how often, and for how long have you been using them? _____

Are you now or have you ever taken a prescription or over-the-counter medication for allergies, stuffiness, difficulty breathing, sinus problems or other nasal problems? If so, please list: _____

Do you currently smoke? ❑ Yes ❑ No

If yes, how many packs per day? _____ How many years? _____

Have you ever smoked? ❑ Yes ❑ No

If yes, how many packs per day? _____ How many years? _____

Do you drink alcohol? ❑ Yes ❑ No

If yes, how much? _____ How often? _____

Do you have any relatives who have had breast cancer? ❑ Yes ❑ No

If yes, who? _____

Have you ever had a mammogram? ❑ Yes ❑ No If yes, when was your last one? _____

Have you had exposure to any of the following:

Radiation: ❑ Yes ❑ No

Excessive sun: ❑ Yes ❑ No

Do you or a member of your family have difficulty with prolonged bleeding when cut? ❑ Yes ❑ No

Do you or a member of your family bruise easily? ❑ Yes ❑ No

Do you have a problem with excessive scarring or keloid formation after being cut? ❑ Yes ❑ No

Have you or a member of your family ever had a problem with anesthesia? ❑ Yes ❑ No

Is your general health good? ❑ Yes ❑ No

Have you ever had psychiatric problems, a nervous breakdown or been under the care of a psychiatrist, psychologist or mental health counselor? ❑ Yes ❑ No

How did you learn about us? *(Please check all statements that apply.)*

❑ My friend, _____ , told me about Dr. Brown.

❑ My doctor, _____, referred me to this office.

❑ Your location is convenient to my home or office.

❑ I visited your web site.

Web site name: Rejuven8u (yellow) Breast Impants Virginia (pink) Breast Augmentation Virginia (green)

❑ Used search engine: Google MSN Yahoo Other:_____

Keyword searched _____.

❑ Referred by another site: _____.

Thank you for taking the time to complete this information.

Please remember to bring this form with you on the day of your visit.