JEV Plastic Surgery and Medical Aesthetics

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The information on this form is essential for us to review so that we may evaluate your entire suitability and safety for treatment. Naturally, all information is strictly confidential. Your time and effort to accurately fill out this form is much appreciated. Thank You!

Date_____

Patient's Name_____ Age_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Phone (Home)_____ (Cell)_____

Married_____ Single_____ Widowed_____ Divorced/Separated_____ Sex (M) _____ (F)_____ (NB) _____

Occupation_____ Employer_____

Work Phone_____ Your e-mail address: _____

Would you like to receive news and specials by email from our office? Yes _____ No _____

Have you, or a family member, ever been to Dr. Vogel's office for a consultation? _____
If so, when? _____

Who referred you?

_____Doctor:_____

_____ Internet ( ) Google Search ( ) Specific Website _____

_____Another Patient: Name Please: _____

_____Other:_____

May we send a thank you note to this referring source? Yes____ No____

Emergency Contact Name: _____ Relationship:_____

Home Phone: _____ Work Phone:_____Cell #:_____

PRESENT INTEREST

Your Area of Interest in our office:
_____

ALLERGIES TO: MEDICATIONS? Yes_____ No_____ Which Ones? _____

LATEX? Yes _____ No _____ **ADHESIVE TAPE?** Yes _____ No_____

If yes to medicines/latex allergies, please describe reaction_____

PAST MEDICAL HISTORY

General Health: Good_____ Fair_____ Poor_____ If not "Good" Please Explain_____

_____

Do You Smoke? Yes_____ No_____ Have you ever smoked? Yes _____ No _____
How Many Packs A Day?_____ For How Long?_____

PREVIOUS SURGERY (please list on the back of this sheet if additional room is needed)

Operation Year Hospital City Surgeon's Name Anesthesia?

_____

_____

Complications After Surgery? Yes_____ No_____ If Yes, Explain_____

Have you ever had nausea after surgery or a tendency to have motion sickness or get car sick? Yes_____No _____
If yes, please explain_____

PRESENT HISTORY

Height_____ Weight_____ Date of Last Physical Exam_____

Name and Address of Family Doctor_____

Serious Illness? (please list)_____

Is there any possibility that you may be pregnant at this time? Yes_____ No_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

PREOPERATIVE INFORMATION: Have you ever had any of the following? (Answer: Yes or No)

Form Keloids_____ Bruise/Bleed Easily _____

High Blood Pressure _____ Heart Disease_____ Diabetes_____

Lung Disease_____ Kidney Disease_____ Asthma_____

VERIFICATION OF INFORMATION AND POLICIES: I certify that the information I have provided is correct. l I realize that I am fully responsible for payment in full to James E. Vogel, MD for services rendered. I understand that all fees are due in advance of treatment **or** on the day of treatment depending on the nature of the service or procedure. I understand that a patient bill of rights is available for me to read if requested.

_____

Signature Date