



Last Name: _____ First Name: _____ DOB: _____ Date: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: Home: _____ Work: _____ Cell: _____
Please circle the phone number you'd prefer confirmation calls: Home Work Cell

Email Address: _____ Occupation: _____

Are you presently single, married, divorced or widowed? _____

Emergency Contact Name & Phone number: _____

Where did you learn about us? : Friend - Family - Print Ad - Internet - Radio - Other: _____

Please circle below the body part you are considering having surgery:
NOSE - CHEEKS - CHIN - LIPS - EYELIDS - FACE - NECK - EARS - SCARS - ABDOMEN - FLANKS - HIPS
- UPPER BACK - LOWER BACK - OUTER THIGHS - INNER THIGHS - BACK OF THIGH - KNEES -
CALVES - ARMS - BRA BULGE - BREAST - MALE CHEST - MONS

What specific features do you dislike? _____

Is having surgery your idea or is someone else urging you to have it? _____

How long have you been thinking about having surgery? _____

Have you read articles in newspapers, internet, magazines or books about cosmetic surgery? Yes___No___

Do you understand that the object of any cosmetic procedure is improvement in appearance, not perfection?
Yes___No___

Why do you happen to select us for consultation? _____

Have you consulted any other surgeon? Yes___No___

Do you realize that every operation is followed by a period of healing before the tissues return to normal and the final result is apparent? Yes___No___

List below any previous cosmetic operation/ procedures you have had:

Where you satisfied with the results? Yes___No___

Where you satisfied with the doctor(s)? Yes___No___ If not, why not? _____

Do you?

Drink more than 6 cups of coffee or tea daily? Yes__No__
Smoke? Yes__No__
Take more than 2 alcoholic drinks every day? Yes__No__
Use marijuana? Yes__No__
Use cocaine, speed, LSD, or heroin? Yes__No__
Have any hobbies? Yes__No__
Spend much time socializing with friends, family group, etc? Yes__No__
Tend to wrap yourself up in your work (school, etc) to almost total exclusion of other aspects of life? Yes__No__
Find that you are unhappy most of the time? Yes__No__
Feel lonely a great deal of the time? Yes__No__

Medical Evaluation

Height: _____ Weight: _____
Have you had any significant **weight change in the last year**? Yes__No__
Have many pounds have lost or gained in the last year? _____ Gender: Male - Female
Do you currently smoke? Yes__ No__ If yes, how much? _____
Do you drink alcohol? Yes__ No__ If yes, how many drinks per week? _____
Have you taken Aspirin, Motrin, Aleve, etc. in the last 2 weeks? Yes__ No__
How often **do you exercise** per week? _____ What kind of exercise do you practice? _____
When was the last time you had a physical exam: _____ Was everything O.K? Yes__ No__
Family Physician's Name: _____ Phone # _____
List any previous surgeries or procedures:

If you have had surgery before, did you have any unusual bleeding or poor scarring following surgery?
Yes__ No__
Did you have a normal recovery following previous surgery?
Yes__ No__
Do you understand that no surgeon can guarantee good results in any operation he performs?
Yes__ No__
Have you ever had hemorrhage following minor surgery?
Yes__ No__
Have you suffered with recurrent nosebleeds?
Yes__ No__

Female Patients:

Number of pregnancies: _____ Did you breastfeed? Yes__ No__ Date of last period: _____
Are your menstrual periods heavy? Yes__ No__

List any current medical conditions:

What **prescription medications** are you taking? Please include dose/frequency.

What **over-the-counter medications** are you taking? (Including vitamins, herbal supplements)

List any drugs or materials to which you are **allergic** and describe the reaction:

Pharmacy Name: _____ **Phone #** _____

List below any other facts of a medical or other nature which you feel you should make known to the Doctor before you undergo any type or surgery or treatment:

Medical History:

- 1) Have you had a heart attack or stroke within the last 12 months? Yes___ No___
- 2) Are you currently taking steroids or any other immunosuppressant medication? Yes___ No___
- 3) Are you currently pregnant or breastfeeding? Yes___ No___
- 4) Are you currently undergoing radiation or chemotherapy for cancer? Yes___ No___
- 5) Do you have history of skin disease or connective tissue disorder? Yes___ No___
- 6) Do you have severe emphysema or other oxygen dependent condition? Yes___ No___
- 7) Are you currently taking Coumadin, Plavix, Aspirin or any other blood thinners on doctor's orders? Yes___ No___
- 8) History of bleeding disorder or excessive bleeding? Yes___ No___
- 9) Do you have a history of keloids or abnormal scarring? Yes___ No___
- 10) Are you allergic to latex? Yes___ No___
- 11) Do you have a progressive neurologic illness? (current paralysis, multiple sclerosis, Parkinson's) Yes___ No___
- 12) Do you have a history of hyper or hypo-pigmentation after skin injury? Yes___ No___
- 13) Are you currently undergoing therapy for a major illness? Yes___ No___
- 14) Do you have a pacemaker? Yes___ No___
- 15) Angioplasty with stent placement? Yes___ No___
- 16) Heart Catheterization/ Stress Test? Date:___ Normal:___ Abnormal:___ Yes___ No___
- 17) High Blood Pressure? Yes___ No___
- 18) Mitral Valve Prolapse? Yes___ No___
- 19) Limited Spine Mobility? Yes___ No___
- 20) Restless leg syndrome? Yes___ No___
- 21) History of abdominal surgery or C-section? Yes___ No___
- 22) Poor Wound Healing? Yes___ No___
- 23) Psychiatric disease that required hospitalization? Yes___ No___
- 24) Reaction to lidocaine? Yes___ No___
- 25) 65 years or older and history of high blood pressure? Yes___ No___
- 26) 70 years or older? Yes___ No___
- 27) Angina or chest pain with exercise? Yes___ No___
- 28) Do you bruise easily? Yes___ No___
- 29) Coronary artery disease or history of heart attacks? Yes___ No___
- 30) Diabetes that cannot be controlled with diet? Yes___ No___
- 31) Hepatitis B or C? Yes___ No___
- 32) Tuberculosis? Yes___ No___
- 33) Sickle cell anemia or trait? Yes___ No___
- 34) History of aortic aneurysm? Yes___ No___
- 35) History of hernia (ventral, umbilical or inguinal)? Yes___ No___
- 36) History of stroke? Yes___ No___
- 37) HIV/AIDS? Yes___ No___
- 38) Irregular heart beat (arrhythmia)? Yes___ No___
- 39) History of kidney insufficiency or failure? Yes___ No___
- 40) Liver insufficiency or Cirrhosis? Yes___ No___
- 41) Phlebitis, blood clot or deep vein thrombosis (DVT)? Yes___ No___

I acknowledge that I have disclosed my complete medical history and the above is completed and accurate to my knowledge of my medical and psychological status. I am at least 18 years of age or, if not, I am accompanied by a legal guardian. I hereby consent to and authorize that Boston Cosmetic Surgery Center staff take a medical history in order to evaluate and plan to help educate me on the possibilities of procedures I can be offered. I understand that photos are helpful and I authorize the taking of photos, which will be used solely for documentation and be kept confidential. Any critical omission or misrepresentation may lead to change in pricing or cancellation.

Please review the above information for accuracy, which you hereby verify by signing below.

Patient Signature

Date

Relationship: (check) Self _____ Spouse _____ Parent _____ Guardian _____



Acknowledgements

1. I deny that I am pregnant or breast feeding at this time and I understand that if I am to undergo a surgical procedure requiring the use of multiple medications that I will notify Dr. Ishoo and his staff prior to surgery if I become pregnant or suspect pregnancy.

Patient Signature

Date

2. Patient covenants and agrees that he/she shall not, in his own name, pseudonymously, or anonymously, hereafter engage in conduct that involves the making or publishing of written or oral statements or remarks (including, without limitation, the repetition or distribution of derogatory rumors, allegations, negative reports or comments) orally, on paper, electronically, or through any other medium, which are disparaging, deleterious or damaging to the integrity, reputation or good will of Owner, Physician and/or Boston Cosmetic Surgery Center.

Patient Signature

Date

3. I understand that I will require an adult escort to accompany me home following the operation as a matter of patient safety because I will have received medications during the procedure. I also understand that I am strictly prohibited from operating a motor vehicle immediately after the operation and for as long as I am taking narcotics or sedatives, which can impair my judgment and motor skills putting others and me at risk for injury. I understand that if I do not have an escort, my surgery will be rescheduled at my expense to a date where one can be made available.

Patient Signature

Date

4. We value our patients' privacy and in order to protect your privacy, it is the policy of this office to prohibit the use of sound, video & other electronic recording devices, including cell phone cameras. The use of such devices is a violation of the right to privacy of both our patients and employees. By signing below, patient agrees that such conduct is an invasion of the privacy of others and will refrain from using recording devices on Boston Cosmetic Surgery Center premises.

Patient Signature

Date

Boston Cosmetic Surgery Center Policies

- We require a credit card number to reserve your appointment. Please give us at least 48 hour notice for appointment cancellations or rescheduling. If you cancel or reschedule your appointment with less than 24 hour notice or fail to come to your appointment, a \$50 charge will be applied to your credit card.
- Our quotes and deposits are valid for 14 days.

Payment Policy:

- We require payment in full at least two weeks prior to the day of procedure, in order for the procedure date to be confirmed. We accept cash, Visa and MasterCard and we also offer financing options through CareCredit®, Chase Health Advanced, and Cosmeti Credit. We do not accept checks.

Refund Policy:

- Boston Cosmetic Surgery Center will not issue refunds for services purchased or rendered. We may, at our sole discretion, issue a full or partial credit for use at our facility towards other services. This credit may not be transferable. We are committed to setting up realistic expectations, however results do vary.
- Our products may be exchangeable for other products, if returned unopened or unused, facility credit, or monetary refund at our sole discretion.

Procedure Change or Cancellation:

- By scheduling and paying a 1/3 and or full payment for your procedure, Edwin Ishoo, M.D. FACS, states that he will perform said procedure on the date you have selected. If you need to change or cancel your surgery within two weeks prior to your surgery, a nonrefundable fee, 20% of the surgical fee or \$500, whichever is greater will be deducted from your credit with us.

Accepted and Agreed To:

Client Signature

Date

