

New Image Cosmetic Surgery Center
Patient Information Sheet
Website

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home: () _____ Cell: () _____ Fax: () _____

E-Mail Address: _____ Restrictions on contacting you? Yes No

If so what are they? _____

Please check all that you are interested in:

- | | | |
|--|--|---|
| <input type="checkbox"/> Abdominoplasty (tummy tuck) | <input type="checkbox"/> Dermal Fillers (Juvederm, etc.) | <input type="checkbox"/> Neck Lift |
| <input type="checkbox"/> Botox | <input type="checkbox"/> Face Lift | <input type="checkbox"/> Otoplasty (ear pinning) |
| <input type="checkbox"/> Brachioplasty (arm lift) | <input type="checkbox"/> Gynecomastia | <input type="checkbox"/> Permanent Make-up |
| <input type="checkbox"/> Blepharoplasty (eye lid lift) | <input type="checkbox"/> (male breast reduction) | <input type="checkbox"/> Post Bariatric Body Lift |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Inverted Nipple Correction | <input type="checkbox"/> Rhinoplasty (nose surgery) |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Labioplasty | <input type="checkbox"/> Scar Revision |
| <input type="checkbox"/> Brow Lift | <input type="checkbox"/> Laser for: _____ | <input type="checkbox"/> Skin Care Products |
| <input type="checkbox"/> Brazilian Butt Augmentation | <input type="checkbox"/> Lip Enhancement | <input type="checkbox"/> Thigh Lift |
| <input type="checkbox"/> Buttock Lift | <input type="checkbox"/> Liposuction | <input type="checkbox"/> Vaginoplasty |
| <input type="checkbox"/> Chemical Peel | <input type="checkbox"/> Mastopexy (Breast Lift) | (vaginal rejuvenation) |

List ALL allergies and reactions: _____

List previous surgeries with dates: _____

Have you or a family member ever had a poor reaction to anesthesia? Please list who had the reaction and what happened.

Do you smoke? Yes No How many per day? _____

Do you drink? Yes No How often and how many drinks? _____

Do you use any recreational drugs? Yes No Please list: _____

Please list all medications with the dose you are taking: _____

Please list any major health issues you may have: _____

How did you find out about us? _____

Thank you for your interest, someone will contact you shortly.