NAME: _____ DATE OF BIRTH: _____

COSMETIC INTAKE

GENERAL INFORMATION

How did you learn about Dr. Wagner? _____

If you learned of us through a friend or physician, who may we thank for referring you? _____

Have you been to our website (www.wagnerplasticsurgery.com)? ☐ Yes ☐ No

If yes, did you find our website helpful? ☐ Yes ☐ No

If No, please provide feedback: _____

Have you consulted with other physicians about procedure(s) indicated above? ☐ Yes ☐ No

If No, please list reason *(i.e. heard Dr. Wagner is the best, just started process, other appointments scheduled...)*

Is this procedure a revision from a previous surgery? ☐ Yes ☐ No

If Yes, how many previous surgeries? _____ Why are you dissatisfied with your result? _____

_____

What is your time preference for your procedure(s)?

☐ Within 1 Month ☐ Within 3 Months ☐ Within 6 Months ☐ Within 12 Months

PROCEDURE INFORMATION

Please indicate the procedure(s) you are interested in below.

FACE	BREAST
☐ Brow Lift ☐ CO2 Laser ☐ Kybella ☐ Liquid Facelift ☐ Lower/Upper Eye Lift ☐ Neck Lift ☐ Rhinoplasty ☐ Scar Revision ☐ OTHER:	☐ Breast Augmentation ☐ Breast Lift (Mastopexy) ☐ Breast Revision/Repair ☐ Breast Implant Exchange ☐ Breast Capsulectomy ☐ Breast Reduction ☐ Breast Asymmetry ☐ Male Breast Reduction (Gynecomastia) ☐ OTHER:

BODY	SKIN
☐ Liposuction ☐ Tummy Tuck ☐ Mommy Makeover ☐ Body Lift ☐ Brazilian Buttlift (Fat Transfer) ☐ Arm Lift ☐ Thigh Lift ☐ Coolsculpting ☐ OTHER:	☐ Botox Cosmetic ☐ Juvéderm (Lip Volume, Laugh Lines) ☐ Vollure (Lip Volume, Shallow Laugh Lines) ☐ Vobella (Lip Line Softening, Light Lip Volume) ☐ Voluma (Defined Cheeks) ☐ Kybella ☐ CO2 Laser ☐ OTHER:

NAME: _____ DATE OF BIRTH: _____

REVIEW OF SYSTEMS

Please indicate whether you are experiencing or suffer from any of the following:

NOTE: *If NONE of the below apply and there are no conditions to add in the "Additional Information" area, check this box to indicate you are NOT experiencing or suffering from any medical conditions.* ☐

GENERAL	Y	N	SKIN	Y	N	EYES	Y	N
Fatigue			Change in Mole Appearance			Blindness		
Fever			Hair Loss			Cataracts		
Sweats			Itching			Glaucoma		
Generalized Weakness			Rash			Vision Changes		
ADDITIONAL COMMENTS:			*ADDITIONAL COMMENTS:*			*ADDITIONAL COMMENTS:*		
GENITOURINARY	**Y**	**N**	**MUSCULOSKELETAL**	**Y**	**N**	**PSYCHIATRIC**	**Y**	**N**
Painful Urination			Arthritis			Anxiety		
Blood in Urine			Artificial Joints			Bipolar Disorder		
Kidney Failure/Dialysis			Fibromyalgia			Depression		
Kidney Stones			Joint Pain / Stiffness			Suicidal Thoughts		
Incontinence			Muscle Cramping			Schizophrenia		
Urinary Tract Infections			Swelling of Joints					
ADDITIONAL COMMENTS:			*ADDITIONAL COMMENTS:*			*ADDITIONAL COMMENTS:*		
HEART	**Y**	**N**	**NEUROLOGICAL**	**Y**	**N**	**GASTROINTESTINAL**	**Y**	**N**
Arrhythmia			Episodes of Vision Loss			Abdominal Pain		
Atrial Fibrillation			Headaches			Black, Tarry Stools		
Chest Pain			Memory Loss			Blood in Stools		
Congestive Heart Failure			Migraines			Constipation		
Fainting Episodes			Multiple Sclerosis			Diarrhea		
Heart Attack			Numbness/Tingling			Heartburn		
Heart Murmur			Paralysis			Hemorrhoids		
Hypertension			Parkinson's Disease			Irritable Bowel Syndrome		
Pacemaker (Please bring card)			Seizure Disorder			Nausea or Vomiting		
Palpitations			Slurred Speech			Rectal Bleeding		
Stents			Stroke			Hiatal Hernia		
			Tremors					
ADDITIONAL COMMENTS:			*ADDITIONAL COMMENTS:*			*ADDITIONAL COMMENTS:*		

EAR/NOSE/THROAT	Y	N	LUNGS	Y	N	HEMATOLOGICAL	Y	N
Dizziness			Chest Pain			Anemia		
Hoarseness			Cough			Blood Transfusions		
Nosebleeds			Coughing with Blood			Leukemia		
Ringing In Ears			History of Lung Nodules			Lymphadenopathy		
Runny Nose			History of Tuberculosis			Prone to Bleeding		
Sinus Infection			Shortness of Breath			Prone to Bruising		
Sore Throat			Sleep Apnea			Sickle Cell Disease		
			Wheezing			Thrombosis (Blood Clots)		
ADDITIONAL COMMENTS:			*ADDITIONAL COMMENTS:*			*ADDITIONAL COMMENTS:*		

***** ARE YOU CURRENTLY PREGNANT? ☐ YES ☐ NO ☐ NOT APPLICABLE

FAMILY HISTORY

Please indicate if anyone in your family has been diagnosed with any of the following:

CONDITION / DISORDER	NONE	MOTHER	FATHER	SIBLING	CHILD	GRANDPARENT
Bleeding Disorder						
Cancer (Non-melanoma)						
Diabetes (Type I)						
Diabetes (Type II)						
Epilepsy						
Heart Disease						
Hypertension						
Glaucoma						
Kidney Disease						
Melanoma						
Stroke						
Thyroid Disease						
Thrombosis (Blood Clots)						

Additional Information - Please elaborate on any pertinent family medical history:

NAME: _____ DATE OF BIRTH: _____

SOCIAL HISTORY

What is your marital status?

☐ Single
☐ Married
☐ Divorced
☐ Separated
☐ Widow / Widower
☐ Domestic Relationship

What is your employment status?

☐ Employed full time
☐ Employed part time
☐ Currently unemployed
☐ Retired
☐ Working at home as MOM
☐ Working at home as DAD
☐ A lucky-duck lottery winner!

What is your primary occupation?

Do you use tobacco products? ☐ YES ☐ NO

Describe your tobacco use, please. (What type of tobacco do you use, and how often.)

What is your tobacco status?

☐ I have never smoked.
☐ I am a former smoker.
☐ I am a light tobacco smoker.
☐ I am a current every day smoker
☐ I am a current some day smoker.
☐ I am a heavy tobacco smoker.

Do you drink alcoholic beverages? ☐ YES ☐ NO

My alcohol usage is:

☐ I drink on special occasions only.
☐ On average, I have less than five alcoholic beverages per week.
☐ On average, I have between five and ten alcoholic beverages per week.
☐ On average, I have in excess of ten alcoholic beverages per week.
☐ I drink alcoholic beverages every day.
☐ I believe I have an alcoholic addiction..

NAME: _____ DATE OF BIRTH: _____

PAST MEDICAL HISTORY

Please indicate whether the following chronic conditions apply.
A Chronic condition is a s persistent or otherwise long-lasting medical condition.

NOTE: *If NONE of the below apply and there are no conditions to add in the "Other" or "Additional Information" areas, check this box to indicate there are no ongoing medical conditions.* ☐

CHRONIC CONDITION	Y	N	CHRONIC CONDITION	Y	N	CHRONIC CONDITION	Y	N
Allergies			Chronic Bronchitis			Hypertension		
Alzheimer's Disease			Cirrhosis			Kidney Disease		
Anemia			Clotting Disorder (Thrombosis)			Lupus		
Anxiety			COPD (Lung Disease)			Lymphoma		
Arrhythmia (Atrial fibrillation, etc.)			Depression			Meningitis		
Arthritis			Diabetes Mellitus Type I			Myocardial Infraction		
Asthma			Diabetes Mellitus Type II			Nerve/Muscle Damage		
Blood Transfusion			Emphysema			Osteoporosis		
Breast Issues			GERD (Heartburn)			Polycythemia Vera		
Cancer *(Specify below)*			Glaucoma			Polymyalgia Rheumatica		
Cataracts			Heart Murmur			Rheumatoid Arthritis		
Congestive Heart Failure			HIV / AIDS			OTHER *(Specify below)*:		

ADDITIONAL INFORMATION - Please provide relevant specific information relating to your past medical history:

Have you had either of the following vaccinations:

Influenza (Flu) ☐ YES ☐ NO Approximate Date _____
Pneumococcal (Pneumonia) ☐ YES ☐ NO Approximate Date _____

SURGERY AND MEDICAL PROCEDURE HISTORY

DATE	NAME OF PROCEDURE / SURGERY	UNDERLYING CONDITION

NAME: _____ DATE OF BIRTH: _____

PHARMACY INFORMATION

What is the name of the pharmacy you would like us to utilize for prescriptions?

What is the address of the pharmacy you listed?

What is the pharmacy telephone number?

MEDICATIONS

Please list *all medications* you take, including *over-the-counter* (OTC) medications and *vitamins*.
Include specific doses and when taken.

If you don't know, please call your pharmacist to confirm.

NAME	DOSAGE	FREQUENCY TAKEN

ALLERGIES

Please list any medical related allergies below (prescriptions, latex, etc.)