

COSMETIC SURGERY OF LAS VEGAS

MR#:



COSMETIC SURGERY
OF LAS VEGAS

DR SAMIR PANCHOLI

Please make every effort to fill out the information fully and accurately.
Your responses are held strictly confidential and are not shared.

Today's Date:

Name			
_____		_____	
First		Last	
Address _____			
_____		_____	
Street & Apt #		City	
		State	Zip
Home Phone _____		Cell Phone _____	Work Phone _____
E-mail _____			
Preferred Method(s) of Contact: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Email			
Please do not contact me by: _____			
Age _____		Birthdate _____	SS# _____
		Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male
Height _____		Weight _____	Number of Children _____
Highest Level of Education <input type="checkbox"/> High School <input type="checkbox"/> Some College <input type="checkbox"/> College <input type="checkbox"/> Masters <input type="checkbox"/> Doctorate			
Marital Status: <input type="checkbox"/> Married: Spouse's Name: _____ <input type="checkbox"/> Single <input type="checkbox"/> Separated/Divorced <input type="checkbox"/> Widowed			
If child, who may authorize treatment? _____			Relationship: _____
Contact : First Name _____		Last Name _____	Relationship _____
Home Phone _____		Cell Phone _____	Other Phone _____
Employer			
_____		Occupation _____	
Address _____			
_____		_____	
Street & Suite #		City	
		State	Zip
Spouse Employer _____		Occupation _____	
Work Phone _____			
Address _____			
_____		_____	
Street & Suite #		City	
		State	Zip
Please indicate your area(s) of interest:			
NON SURGICAL	FACE	BREAST	BODY
<input type="checkbox"/> Botox <input type="checkbox"/> Wrinkles <input type="checkbox"/> Skin Filler <input type="checkbox"/> Lip Enhancement <input type="checkbox"/> Smile or Nasolabial Lines <input type="checkbox"/> Skin Care / Enhancement <input type="checkbox"/> Obagi Blue Peel <input type="checkbox"/> Other	<input type="checkbox"/> Eyes - Blepharoplasty <input type="checkbox"/> Ears - Otoplasty <input type="checkbox"/> Nose - Rhinoplasty <input type="checkbox"/> Facial Implant - Cheeks <input type="checkbox"/> Facial Implant - Chin <input type="checkbox"/> Forehead/Brow Lift <input type="checkbox"/> Facial Sculpting <input type="checkbox"/> Necklift <input type="checkbox"/> Facelift <input type="checkbox"/> Other	<input type="checkbox"/> Breast Enlargement <input type="checkbox"/> Breast Implant Deflation <input type="checkbox"/> Breast Implant Change <input type="checkbox"/> Breast Lift <input type="checkbox"/> Breast Reduction <input type="checkbox"/> Male Breast Reduction <input type="checkbox"/> Other	<input type="checkbox"/> Liposuction <input type="checkbox"/> Tummy Tuck <input type="checkbox"/> Labiaplasty <input type="checkbox"/> Arm Reduction <input type="checkbox"/> Brazillian Butt Lift <input type="checkbox"/> Other
Please use this space to provide any other information you feel may be helpful to your consultation:			

Have you been educated about these procedures with other Surgeons? Yes No

Procedure _____	Doctor _____	How long ago? _____
Procedure _____	Doctor _____	How long ago? _____
Procedure _____	Doctor _____	How long ago? _____
Procedure _____	Doctor _____	How long ago? _____

How did you hear about Dr. Pancholi? Patient (Mark all that apply)

<input type="checkbox"/> www.drpancholi.com	<input type="checkbox"/> Radio: _____
<input type="checkbox"/> Email Promotion: _____	<input type="checkbox"/> Business: _____
<input type="checkbox"/> Website: _____	<input type="checkbox"/> Phonebook: _____
<input type="checkbox"/> Magazine: _____	<input type="checkbox"/> Newspaper _____
<input type="checkbox"/> Event: _____	<input type="checkbox"/> TV Show: _____
<input type="checkbox"/> General Reputation	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Friend/Relative:	<input type="checkbox"/> Doctor: _____

Medical History

Your medical history is an extremely important part of your consultation. It helps alert us to any potential conditions that may interfere with your surgery. Please take your time and fill this out as completely and accurately as possible. If you need any help or have questions, our staff will be happy to assist you.

List **All Prescription and Non Prescription** medications you are taking:

List any **Medical Conditions** you have or had:

List any **Surgery** you have had (including Cosmetic Surgery) **with dates**:

List any serious **Major Illness / Injury** you have had in the past:

List any **Diet Pills** you take (May cause problems with anesthesia):

List any **Drug Allergies**:

List any **Contact Allergies** (latex or other products):

Describe any difficulties you have had with **anesthesia**:

List any hereditary disorders that run in your family:

Breast Cancer Family History: Do you have:

- 2 or more relatives with breast cancer A male relative with breast cancer
 2 or more relatives with ovarian cancer A relative with got breast cancer before age 50
 A relative with both breast and ovarian cancer An Ashkenazi Jewish heritage relative with breast or ovarian cancer

Do you Smoke? No Yes: What? _____ How much per week? _____ How many years? _____

Do you drink Alcohol? No Occasionally 1-2 drinks daily 3 or more drinks daily

Do use any Recreational Drugs?

No Yes: What? _____ Times a Week? _____ How Many Years? _____

Are you or have you ever had an addiction to narcotics or recreational drugs?

No Yes: What? _____ Duration of use? _____ Date of last use: _____

How do you rate your general health? Poor Fair Good Excellent

Are you under a doctor's care? No Yes: Whom? _____

Review the list below and check anything applicable. If you check any box, use the space below to explain further if needed.

- | | | |
|---|---|---|
| <input type="checkbox"/> Chronic Skin condition | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Blood in Urine or trouble urinating |
| <input type="checkbox"/> Severe drynes of the eyes | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Bleeding disorders (you or family) |
| <input type="checkbox"/> Glaucoma or blurry vision | <input type="checkbox"/> Chronic hoarseness | <input type="checkbox"/> Blood clots (you or family) |
| <input type="checkbox"/> Wear Glasses/Contacts | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Menstrual disorder |
| <input type="checkbox"/> Drainage from ears | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Easy bruising |
| <input type="checkbox"/> Difficulty Hearing | <input type="checkbox"/> Racing heart rate without cause | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Altered Thyroid hormone levels |
| <input type="checkbox"/> Recurrent severe dizziness | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Nasal Injury | <input type="checkbox"/> Swollen legs and ankles | <input type="checkbox"/> Low blood sugar |
| <input type="checkbox"/> Frequent Nose bleeds | <input type="checkbox"/> Stroke | <input type="checkbox"/> Always thirsty or urinating |
| <input type="checkbox"/> Difficulty Breathing from Nose | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sensation changes |
| <input type="checkbox"/> Difficulty Smelling | <input type="checkbox"/> Abnormal lump | <input type="checkbox"/> Treated/Tested positive for Tuberculosis |
| <input type="checkbox"/> Chronic Sinus Infections | <input type="checkbox"/> Enlarged lymph node | <input type="checkbox"/> Treated/Tested positive for HIV |
| <input type="checkbox"/> Frequent Nasal Allergies | <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Treated/Tested positive for AIDS |
| <input type="checkbox"/> Chronic sinus/nasal blockage | <input type="checkbox"/> Problems with bones or joints | <input type="checkbox"/> Treated/Tested positive for Hepatitis |
| <input type="checkbox"/> Difficulty with Taste | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hospitalized for mental illness |
| <input type="checkbox"/> Recurrent fever blisters | <input type="checkbox"/> Joint Disease | <input type="checkbox"/> Emotional/Psychological concern |
| <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Under Psychiatric care |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Alcoholism / Drug Addictions |
| <input type="checkbox"/> Paralysis (Face or Body) | <input type="checkbox"/> Chronic Abdominal problems | <input type="checkbox"/> Complications after surgery |
| <input type="checkbox"/> Shortnes of breath | <input type="checkbox"/> Yellow Jaundice or Hepatitis | <input type="checkbox"/> Bad/ unsatisfactory surgical outcome |
| <input type="checkbox"/> Sleep on pillows to help breathing | <input type="checkbox"/> Blood in Bowel movements / Stool | <input type="checkbox"/> <u>NONE OF THE ABOVE</u> |
| <input type="checkbox"/> Asthma or emphysema | <input type="checkbox"/> Kidney or bladder problems | <input type="checkbox"/> Other: _____ |

Please explain:

Consultation Fee: \$100. I understand this fee is due in full today and will be applied to the full balance of surgical services requested. I understand that I am responsible for all bills being paid in a timely manner and that this contract is between Dr. Pancholi and myself.

I have read this form entirely and have completed it fully and accurately to the best of my knowledge.

Patient Signature

Date

Dr. Pancholi Signature

Date Reviewed