

The Woodruff Institute
2235 Venetian Court
Naples, FL 34109

COSMETIC SURGEY MEDICAL QUESTIONNAIRE

Name: _____ D/O/B: _____ Today's Date: _____
Occupation: _____ Marital Status: Single Married Divorced Widowed Separated
Spouse's Name: _____
How were you referred to us? _____

In which surgical procedure (s) or area are you interested in discussing?
Rhinoplasty (nose) _____ Chin _____ Face or Neck Lift _____ Eyelids _____ Chemical Peel _____
Laser _____ Dermabrasion _____ Scar Revision _____ Protruding Ears _____
Removal of Cyst, Wart, Moles _____ Hair Transplantation _____ Other _____
What aspect do you wish to have corrected? _____

When did you consider surgical corrections? _____

Why have you decided to have it done at this point and time? _____

Have you consulted any other doctor about this? _____

Have you discussed this surgery with your family? **YES NO** Are they agreeable? **YES NO**

Have you had **any** previous cosmetic surgery? **YES NO**

When, where and what was done? _____

Who performed the surgery? _____ Where you satisfied with the results? _____

If not, why? _____

Have you had any other surgery or an injury to the face, nose, neck, or eyes? _____

When? _____ Describe: _____

Have you had any other prior surgery? _____

What was done and when was it performed? _____

Were there any complications? _____

Did you have any problems with anesthesia? _____

Did you have a normal recovery? _____ Were you satisfied with the results? _____

If not, why? _____

MEDICAL HISTORY

When was your last physical? _____ Who is your family doctor? _____

Family doctor's address: _____

Would you object to our contacting him/her in regard to any medical problem that might arise? _____

Do you or your family members have: (Indicate who) Heart trouble _____ Diabetes _____

Excessive bleeding tendencies _____ Tuberculosis _____ Thyroid problems _____

High Blood Pressure _____ Excessive bruising _____ Excessive scarring _____

Psychiatric or "nerve" problems _____

Do you have a family history of bleeding:

From the nose _____ In the urine _____ Vomiting blood _____

From the rectum _____ Coughing up blood _____ Other _____

