CRUISE PLASTIC SURGERY

Patient Information

I would like to be addressed as: ______________________
(Preferred Name/Nickname)

Name ______________________
First Middle Last

Address ______________________
Street & Apt # City State Zip

Home Phone __________ Cell Phone __________ Other Phone __________

Any restrictions for contacting you? ❒ No ❒ Yes E-mail __________

Contact Restrictions: __________ Drivers License # (include State) __________

Age ____ Birthdate __________ Sex ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: __________

Children ❒ Yes ❒ No Ages: __________

Occupation __________ Work Phone __________

May we call you at work? ❒ Yes ❒ No

Emergency Contact (f we cannot get in touch with you. We will contact this person) Name __________ Relationship __________
Phone __________

How did you hear about us?

❒ Internet	❒ From Previous Patient __________	❒ Word of Mouth
❒ Gynecomastia.org	❒ Friend/Relative... __________	❒ Walk In
❒ MakeMeHeal.com	❒ Plastic Surgery News Magazine	❒ Other __________

If you were referred by a specific person, may we thank them? ❒ Yes ❒ No

Procedure Information

What is your primary area of concern today? __________

What procedure(s) are you interested in? __________

How long have you been thinking about this? __________

Has anything happened recently to stimulate your interest in having this done? __________

What are your goals from the surgery? __________

Why did you select Dr. Cruise as a candidate to perform this surgery? __________

Have you had other consultations? ❒ Yes ❒ No __________ Dr. __________ Dr. __________

When are you thinking about having this done? ❒ASAP ❒1 month ❒2-3 months ❒3 > months

History and Physical

Patient's Name ____
First Middle Last

Age ________ Birthdate ______________ Height _________ Weight _________ Gender ❒ Female ❒ Male

Purpose of Visit: ____

____

Previous Cosmetic and General Surgeries

Surgery	Date	Surgeon

Health Problems Past & Present: (mark all that apply)

❒ Diabetes
❒ Easy Bruising
❒ Cancer
❒ Bleeding/Clotting Problems
❒ Bleeding Tendency or Disorder
❒ Glaucoma or Eye Problems
❒ Dry Eye
❒ Abdominal Hernia
❒ Liver Problems
❒ Problem Constipation
❒ High Blood Pressure
❒ Lung/Breathing Problems
❒ Shortness of Breath
❒ Chest Pain
❒ Asthma
❒ Seizures or Convulsions or Fainting Spells
❒ Thyroid Problems
❒ Kidney or Renal Disease
❒ Positive Blood Test for HIV, AIDS, Hypotatis
❒ Use of Recreational Drugs Within Last 3 Months
❒ Heart Problems
❒ Heart Attack
❒ Palpitation or Irregular Pulse
❒ Stroke
❒ Alcohol Dependancy
❒ Nervous Disorder
❒ Psychiatric / Depression
❒ Other:

❒ Breast Patients Only – Family History of Breast Cancer ❒ Yes ❒ No

Comments: ____

Is there anything else you think the doctor should know ? ______________________________

____

Do you smoke? ❒ Yes ❒ No , How many packs a day? ___________

Medications: (Include all Prescriptive, Over-The-Counter, Vitamins and Herbal medications taken regularly)

____

____

____

Drug or Latex Allergies: ❒ Yes ❒ No ____

____

____

Have you ever taken: **Vicodin** ❒ Yes ❒ No **Darvocet** ❒ Yes ❒ No ____________________

Did you have any problems with either? ______________________________

Do you have a pain medication that works well for you? ______________________________

Health Insurance ______________________________ Policy# ____________________

Primary Physician ______________________________ Phone ____________________

First and Last Name

Date of Last Physical: ______________

Secondary Areas of Concern/Future Procedures		
Face/Neck	**Body**	**Other**
❒ Upper Eyes	❒ Abdomen	❒ Ears
❒ Lower Eyes	❒ Breasts	❒ Lips
❒ Cheeks	❒ Upper Back	❒ Fine Lines/Wrinkles
❒ Nose	❒ Lower Back	❒ ____________
❒ Chin	❒ Thighs	❒ ____________
❒ Neck		❒ ____________
❒ Loose Skin/Jowling		

____ Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment.
Initial
I have been given the opportunity to review the uses and disclosures of protected health information about me for all of the purposes set out in our Notice.

____ NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322, www.mbc.ca.gov.
Initial

The above information is accurate and complete to the best of my knowledge.

Signature ______________________________ **Date** ____________________