

**E-MAIL ADDRESS:** \_\_\_\_\_

By providing us with your e-mail address we will keep you updated with promotions and special events.

Today's Date \_\_\_\_\_

Name: Mr. Miss Ms. Mrs. Dr. \_\_\_\_\_  
LAST FIRST MIDDLE

How would you like to be addressed by our office staff? \_\_\_\_\_

PHONE NUMBERS: **PLEASE CHECK WHICH PHONE NUMBER IS BEST TO REACH YOU.**

Home \_\_\_\_\_  Work \_\_\_\_\_  Cell \_\_\_\_\_

Address: \_\_\_\_\_  
STREET APT# CITY STATE ZIP

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Ethnicity:**  Caucasian  African-American  Asian/Pacific Islander  Hispanic  other \_\_\_\_\_

Have you visited our website? (www.maeplasticsurgery.com) Yes \_\_\_\_\_ No \_\_\_\_\_

**How did you hear about our practice? Please check any and all that apply.**

**Friend/Patient** – If this person is a patient, please let us know his/her name \_\_\_\_\_

**Physician** – Please let us know his/her name \_\_\_\_\_

**Advertisement or News Story:**  New Beauty Magazine  Chicago Magazine

**Websites** – please check the website(s) where you found information about our practice:

maeplasticsurgery.com  Newbeauty.com  lookingyourbest.com  implantinfo.com  liposite.com

faceforum.com  aboardcertifiedplasticsurgeonresource.com  chicagolipodrs.com  chicagobreastdrs.com

realself.com  vitals.com Other Website(s): \_\_\_\_\_

**Other** – Please let us know how you heard about us \_\_\_\_\_

What is your current weight? \_\_\_\_\_ Ideal weight? \_\_\_\_\_ Height? \_\_\_\_\_

**PLEASE LIST ANY MEDICATIONS YOU HAVE RECENTLY TAKEN OR ARE CURRENTLY TAKING (INCLUDING ASPIRIN OR IBUPROFEN PRODUCTS AND VITAMINS/SUPPLEMENTS)**

**DO YOU HAVE ANY ALLERGIES TO MEDICATIONS?  YES  NO**

**If so, please list:** \_\_\_\_\_

**MEDICAL HISTORY (Please check all that apply)**

Have you ever smoked or do you currently smoke? Yes \_\_\_\_\_ No \_\_\_\_\_? If yes, how much? \_\_\_\_\_

Heart disease \_\_\_\_\_ Sleep apnea \_\_\_\_\_ Gastric Lap Banding \_\_\_\_\_ Gastric Bypass \_\_\_\_\_ Heart murmur \_\_\_\_\_

High blood pressure \_\_\_\_\_ Diabetes \_\_\_\_\_ Immune disorders \_\_\_\_\_ Arthritis \_\_\_\_\_ Back problems \_\_\_\_\_ Kidney stones \_\_\_\_\_

Seizure disorders \_\_\_\_\_ Anemia \_\_\_\_\_

Are you currently pregnant?  Yes  No Pregnancies \_\_\_\_\_ Normal Deliveries \_\_\_\_\_ C-Sections \_\_\_\_\_  
Miscarriages/Abortions \_\_\_\_\_

Are you currently breast feeding?  Yes  No Did you breast feed?  Yes  No

Do you have history of breast cancer?  Yes  No Maternal side  Yes  No Paternal side  Yes  No

Have you ever had a mammogram?  Yes  No Date: \_\_\_\_\_

Please list any other medical problems here

Do you have any problems with bruising \_\_\_\_\_ or bleeding \_\_\_\_\_? If yes, please explain \_\_\_\_\_

Have you ever had a problem with your nerves \_\_\_\_\_ or muscles \_\_\_\_\_? If yes, please explain \_\_\_\_\_

(Temporary paralysis, nerve injuries, strokes, etc).

Have you ever been treated for any psychiatric illness \_\_\_\_\_? If yes, please explain \_\_\_\_\_

Do you wear dentures? \_\_\_\_\_ or a retainer \_\_\_\_\_ of any kind?

Do you get fever blisters \_\_\_\_\_ or other cold sores \_\_\_\_\_ on your lips? If yes, how often \_\_\_\_\_

Do you exercise regularly? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, how often? \_\_\_\_\_

List all diseases that run in your family: \_\_\_\_\_

***SURGICAL HISTORY***

Please list all NON-COSMETIC surgeries and approx dates, other injuries and/or hospitalizations, reasons for treatment, etc.

1) \_\_\_\_\_ 4) \_\_\_\_\_

2) \_\_\_\_\_ 5) \_\_\_\_\_

3) \_\_\_\_\_ 6) \_\_\_\_\_

***COSMETIC HISTORY***

Please list all COSMETIC surgeries and the SURGEONS who performed them (including injections, i.e. Botox, Collagen)

NAME OF PROCEDURE, NAME OF SURGEON, DATE

1) \_\_\_\_\_ 3) \_\_\_\_\_

2) \_\_\_\_\_ 4) \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(Parent/Guardian signature if patient is under 18 years old)

Name \_\_\_\_\_

Date \_\_\_\_\_

What is the main purpose of your visit today? \_\_\_\_\_

**Are you interested in learning more about any of the following? Please check those that apply.**

- Facial Rejuvenation Surgery
- Nasal Reshaping Surgery
- Body Contouring Surgery
- Breast Augmentation Surgery
- Eyelid Surgery – upper and/or lower
- Other – Please list your interests here

**Would you be interested in non-surgical treatments for:**

- Frown lines between the brows
- Significant lines around the nose & mouth
- Fine lines and wrinkles
- Tired looking or dull skin
- Facial Hair
- Sagging Facial Skin
- Age Spots/Facial Pigmentation Problems
- Treatments for Dark Circles under the Eyes
- Acne
- Dry Skin
- Oily Skin
- Rough Skin

**Do you have any interest in the following:**

- BOTOX treatments for wrinkle correction
- BOTOX treatments for underarm sweating or sweaty palms
- Dermal Fillers (Juvederm, Restylane, Radiesse, Belotero, Sculptra, Artefill)
- Facials
- Chemical Peels
- Microdermabrasion, Dermaplaning
- Overall Skin Rejuvenation/Skincare Advice
- Medical-grade skincare products
- Laser Treatments for hair removal
- Laser Treatments for skin resurfacing (DOT Therapy)
- LipoSonic Therapy treatments for melting away pockets of fat
- Laser treatments for skin rejuvenation (red spots, brown spots, sundamage)

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Thank you for your time!



## **ACKNOWLEDGEMENT FORM**

### **Acknowledgement of Receipt of Privacy Notice**

I have been presented with a copy of the **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice.

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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