Robert W. Kessler, MD, FACS

Patient Interest Wish List

Check the procedures(s) you're interested in

Patient Name:____Date:______________________

Facial Skin/ Fine lines & Wrinkles (please check all that apply)

- ❑ Facial Plastic Surgery
- ❑ Facial fullness/drooping
- ❑ Facial Contouring
- ❑ Ear size / shape
- ❑ Nose size or shape
- ❑ Drooping brow
- ❑ Upper or Lower eyelids
- ❑ Mole removal
- ❑ Scar revision
- ❑ Frown lines / fine lines / wrinkles
- ❑ Botox
- ❑ Sculptra (volumizer)
- ❑ Fillers (Juvederm / Voluma / Volbella / Radiesse)
- ❑ Thin lips
- ❑ Ultherapy
- ❑ Neck wrinkles
- ❑ Collagen Therapy (Dermaroller)
- ❑ Laser Treatment (resurfacing)
- ❑ Chemical peel
- ❑ Brown spots /age spots/freckles / texture
- ❑ Skin care
- ❑ Other, please specify:____

Upper Body (please check all that apply)

- ❑ Breast size / shape
- ❑ Breast implant concerns
- ❑ Hands/Arms

Lower Body:

- ❑ Abdominal area
- ❑ Hips
- ❑ Thigh Lift
- ❑ Body Contouring
- ❑ HCG Diet
- ❑ Vanquish (permanent fat reduction & skin tightening)

When would you like to do this?____

Please describe your current skin care regimen:

- ❑ Cleanser____
- ❑ Moisturizer____
- ❑ Sunscreen____
- ❑ Anti-aging products

____

Would you like to receive special offers from our office through our email newsletter?

Please circle one: YES / NO

Patient's Full Name:____

Date of Birth:____/____/____ Age:_______________ Social Security #:______________________________

Mailing Address: ____

City:____ State:___________ Zip Code:____________

Today's Date:____/____/____ For a consultation regarding:_________________________________

Phone Numbers: ***PLEASE INDICATE THE BEST WAY TO GET A HOLD OF YOU***

Home:____is it ok to leave messages here?_______

Work:___________________________ext_______________is it ok to leave messages here?_______

Cell:____is it ok to leave messages here?_______

Fax:_____________________________

E-mail:____ ________

How Did You Hear About Us?:

[ ] Internet [ ] TV Ad [ ] Phone Book [ ] Magazine [ ] Newsletter [ ] Seminar [ ] Salon

Friend/Relative: ________________________________ Doctor: __________________________________

Other: ____

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

Emergency Contact Information:

Name:____

Relationship:____________________________ May we contact this person? _________

Phone:_______________________________ 2nd Phone:____________________________

MEDICAL HISTORY QUESTIONNAIRE

Name: ____ Today's Date: ____________

Age: _________ Height:__________ Weight:____________

Have you ever been evaluated by a plastic surgeon for this procedure before? *Yes or No*
Have you ever smoked? *Yes or No* Packs per Day _____ How many years? ______ Quit when? _____
Do you drink alcohol? *Yes or No* How much? _______________ How often? ____________

Have you ever had:

Exam by Cardiologist / Exercise or Thallium Stress Test / Echocardiogram / Heart Catheterization

For Women Only:
Do you have any children? *Yes or No* If yes, how many? _______ Planning additional children? _______
How long since last pregnancy? ____________ How long since last breast feed? ____________
List relatives with breast cancer: ____
When was last mammogram? _________ *or Never*

List ALLERGIES / REACTIONS	List Previous Surgeries/ Hospitalizations	Dates

Medications	Dose	How Often	Reason

DO YOU HAVE OR HAVE EVER HAD:	*YES*	*NO*
COLD SYMPTOMS/FEVER IN PAST 2 WEEKS		
BRONCHITIS OR CHRONIS COUGH		
ASTHMA OR HAY FEVER		
PNEUMONIA OR TUBERCULOSIS		
EMPHYSEMA OR SHORT BREATH		
SLEEP APNEA		
HIGH BLOOD PRESSURE/ LOW BLOOD PRESSURE		
HEART ATTACK/ ANGINA/ CHEST PAIN		
CONGESTIVE HEART FAILURE		
IRREGULAR HEART BEAT/ ARRHYTHMIAS		
PROBLEMS WITH HEART VALVES/ MURMURS		
PACEMAKER/ AUTOMATIC DEFIBRILLATOR		
STROKE/ TIA (TRANSIENT ISCHEMIC		
WEAKNESS/ PARALYSIS		
GLAUCOMA		
POLIO/ MENINGITIS/ MUSCLE DISEASE		

	YES	NO
SEIZURES/ EPILEPSY		
DEPRESSION/ ANXIETY		
FAINTING/ DIZZINESS		
KIDNEY DISEASE/ DIALYSIS/ PROBLEMS VOIDING		
JAUNDICE/ HEPATITIS/ LIVER PROBLEMS		
ANEMIA		
SICKLE CELL DISEASE/ TRAIT		
PHLEBITIS/ BLOOD CLOTS/ EMBOLISM		
PROBLEMS WITH POOR CIRCULATION		
BLOOD TRANSFUSION		
HIV/ AIDS		
CHRONIC HEARTBURN/ REFLUX/ STOMACH ULCERS		
THYROID DISEASE		
CHRONIC BACK PAIN		
DIABETES		

Who is your personal physician, if any? ____
Please list all physicians presently caring for you: ______________________________________
Have you ever been under psychiatric care? [ ] Yes [ ] No When? _____________ Why ? ____________________

Dr. Robert W. Kessler, M.D. F.A.C.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I,**____**(Print Name) have received a copy of Robert W. Kessler, MD, FACS Notice of Privacy Practices.

____

(Signature)

____

(Date)

____For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An Emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)