The Plastic Surgery Experts

Mark Mandell-Brown, M.D., Director.

Name _____ Date of Birth _____

Phone # _____ Cell # _____Work # _____

How were you referred to us? _____

Please circle surgical procedures you are interested in:

Breast Augmentation Facelift Botox Facial Fillers

Breast Lift Breast Reduction Rhinoplasty Tummy Tuck

Arm Reduction Eyelids Facial Peels Browlift Liposuction

Laser: Skin Resurfacing, Hair or Veins Lip Enhancement Moles/Cysts

What specifically do you wish to have corrected? What don't you like? _____

_____

Do you desire improvement in both appearance and function? Yes _____ No _____
When did you begin to consider surgical corrections? _____
Why have you decided to have it done at this point in 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? _____
What kind of surgery or procedure? _____
Who performed the surgery? _____
Are you satisfied with the result? Yes / No If not, Why? _____
Have you had an injury to face, nose, neck, eyes or chest? Yes / No
When? _____ Describe surgery/injury _____
Any complications? _____
Has anyone in your family or a close friend had cosmetic or reconstructive surgery? Yes / No
What kind of surgery or procedure? _____ by whom? _____
Were they satisfied with the results? Yes / No Explain? _____
Do you accept the fact that every medical and surgical treatment is associated with risk? Yes / No
Medical History: Any Allergies to Medications? _____
List any medications you are currently taking _____
Family Medical Doctor _____ Phone # _____
When was your last physical exam? _____
May we contact your family MD regarding your history? Yes / No

Mandell-Brown Plastic Surgery Center
10735 Montgomery
Cincinnati, Ohio 45242

Please Circle

Do you have a history of bleeding? Explain _____ Yes No
Have you ever received local anesthesia (Novocaine/Xylocaine)? ……. Yes No
Did you have any reaction to any anesthetic/anesthesia? …… Yes No
Are you considered a healthy person? …… Yes No
Do you take vitamins regularly? …… Yes No
Do you have hay fever, nasal allergies or asthma? …….. Yes No
Do you have frequent pains in the chest or been told you have “Heart Trouble”? Yes No
Do you have any problem with your eyes or vision? ……. Yes No
Do you have stomach trouble or ulcers? …… Yes No
Do you have or had chest or lung problems? ……. Yes No
Have you ever had liver, gall bladder problems or yellow jaundice? …….. Yes No
Have you been bothered by kidney or bladder problems? …… Yes No
Do you or any family member suffer from arthritis? …… Yes No
Do you have frequent skin infections, irritations or rashes? ……. Yes No
Do you ever get cold sores? …….. Yes No
Do you often have severe headaches or dizzy spells? …… Yes No
Has any part of your body ever been paralyzed or numb? …… Yes No
Did you ever have a convulsion or seizure? …… Yes No
Have you ever been treated for any venereal disease? Yes No
Are you frequently sick or ill? ……. Yes No
Do you worry about your health? …….. Yes No
Were you ever treated for anemia or any blood problem? …… Yes No
Have you ever taken hormones or thyroid medication? …… Yes No
Do you smoke? How much daily? _____..... Yes No
Do you drink more than 6 cups of coffee/caffeinated drinks daily? Yes No
Do you usually take 2 or more alcoholic drinks daily? …….. Yes No
Have you ever received treatment for abuse of alcohol or drugs? ……. Yes No
Do you often get depressed or feel unhappy? …… Yes No
Did you ever have a nervous breakdown? …….. Yes No
Are you easily able to get upset or irritated?…… Yes No
Do you tend to hold a “Grudge” when someone angers you? ……Yes No
Does change make you anxious?..... Yes No
In terms of being a “controlling person”, on a scale of 1-10 (10 being the most), how would you rate yourself? _____
Have you ever considered consulting a psychiatrist or psychologist? …… Yes No
If you answered “YES” to any of the questions or have any medical problems not addressed please explain in detail (when, how long, complications)?

_____

_____

Do you or any family members have (Please Circle)?

Heart Trouble	Diabetes	High Blood Pressure	Thyroid Problems
Excessive Bleeding	Delayed Hearing	Excessive Scarring	Psychiatric Problems

Signature: _____ Date: _____

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