HEALY PLASTIC SURGERY
JEFF T HEALY MD

PATIENT INFORMATION (Please Print)

Last Name: _____ First Name: _____
Address: _____ City, State, Zip: _____
Home Phone: _____ Cellular: _____ Work: _____
E-mail Address:_____ Can we contact you through e-mail: yes_____ no_____
Date of Birth _____ Sex: M or F
Marital Status: _____ Employed: yes___ no___ Employer: _____

WHAT PROCEDURES ARE YOU INTERESTED IN?

BREAST:
- ☐ Breast Augmentation
- ☐ Breast Lift
- ☐ Breast Reduction
- ☐ Breast Revision

BODY:
- ☐ Tummy Tuck
- ☐ Liposuction
- ☐ Arm Lift
- ☐ Thigh Lift
- ☐ Lower Body Lift
- ☐ Labiaplasty
- ☐ Gynecomastia

FACE:
- ☐ Face Lift
- ☐ Brow Lift
- ☐ Eyelids
- ☐ Mole(s)

INJECTIONS:
Area_____
- ☐ Botox
- ☐ Fillers

LASER:
- ☐ Hair Removal
- ☐ Vein Therapy
- ☐ Laser Facial

SKIN:
- ☐ Skincare Services
- ☐ Skincare Products
- ☐ Eyelashes
- ☐ Massage
- ☐ Chemical Peel
- ☐ Waxing
- ☐ Threading

OTHER: _____

MISCELLANEOUS

Emergency Contact:_____ Relationship:_____ Phone:_____

HOW DID YOU HEAR ABOUT DR. HEALYS OFFICE?

Friend:_____ Name:_____
Internet:_____ Website:_____
Doctor Referral:_____ Doctor's Name:_____
Other:_____ Name _____

PATIENT HISTORY

***MEDICAL HISTORY*:**

Medical Problems: (e.g. diabetes, high blood pressure, heart problems, lung problems)

_____

_____

Previous Surgery**:** _____

Medications: (including over the counter medications) _____

_____

Allergies: _____

***SOCIAL HISTORY*:**

- Children? _____
  - How Many? _____
- Do you smoke? _____
  - Packs per day? _____
  - When did you quit? _____
  - Other Tobacco products? _____
- Do you drink alcohol? _____
  - How many drinks per week? _____
- Do you use recreational drugs? _____
  - What type? _____
  - How often? _____

***EXERCISE HISTORY*:**

What type of exercise do you do? _____

How often? _____

Date: _____

Patient: _____

Signature: _____

Relationship if not patient:

( ) Parent **( )** Legal Guardian

( ) Other, Specify _____

DOCTOR'S NOTES:

_____

_____

_____

_____

_____