GRAPER COSMETIC SURGERY

Robert Graper, M.D. F.A.C.S

Reason For Visit

What is your anticipated type of procedure?

- ☐ Body contouring
- ☐ Botox
- ☐ Breast augmentation
- ☐ Breast lift
- ☐ Breast reduction
- ☐ Breast reconstruction
- ☐ Breast revision
- ☐ Breast surgery
- ☐ Browlift
- ☐ Chemical peel
- ☐ Eyelid surgery
- ☐ Faceflift
- ☐ Fillers
- ☐ Laser
- ☐ Lesion
- ☐ Lip augmentation
- ☐ Other
- ☐ Rhinoplasty

Height/Weight/BMI/BSA

	Date 1	Date 2	Date 3
Date:	_____	_____	_____
Height (ft):	_____	_____	_____
Height (in):	_____	_____	_____
Weight (lbs) by your scale:	_____	_____	_____
Weight (lbs) per patient:	_____	_____	_____
BMI	_____	_____	_____
BSA	_____	_____	_____

Pregnancy Information

Number of pregnancies	_____
Number of child deliveries	_____
Number of vaginal deliveries	_____
Number of Cesarian deliveries	_____
Maximum weight gain	_____

Patient Smoking History

- ☐ **DENIES**
  - ☐ Denies tobacco use
- ☐ **QUIT**
  - ☐ quit <1 year ago
  - ☐ quit <1-5 years ago
  - ☐ quit >5 years ago
- ☐ **PACKS PER DAY**
  - ☐ <1 pack per day
  - ☐ 1 pack per day
  - ☐ 2 packs per day
- ☐ **LENGTH**
  - ☐ for <5 years
  - ☐ for 5-10 years
  - ☐ for 10-15 years
  - ☐ for 15-20 years
  - ☐ for >20 years

2915 Coltsgate Road • Suite 103 • Charlotte, NC 28211 • P 704.375.7111 • F 704.375.0444
www.grapercosmeticsurgery.com

Do you have or have had any of the following?

	Yes	No	If yes, please explain
Asthma	☐	☐	_____
Chronic cough	☐	☐	_____
Chronic bronchitis	☐	☐	_____
Sleep apnea	☐	☐	_____
Emphysema	☐	☐	_____
Heart murmur	☐	☐	_____
Mitral Valve Prolapse	☐	☐	_____
Have you ever been told to take antibiotics prior to dental work?	☐	☐	_____
High blood pressure	☐	☐	_____
Skipped heart beats	☐	☐	_____
Chest pains	☐	☐	_____
Heart attack or failure	☐	☐	_____
Have you seen a cardiologist?	☐	☐	_____
History of anemia	☐	☐	_____
Do you have sickle cell disease?	☐	☐	_____
Other blood diseases	☐	☐	_____
Abnormal blood clotting	☐	☐	_____
Hepatitis	☐	☐	_____
Jaundice or other liver disease	☐	☐	_____
Kidney infections (frequently)	☐	☐	_____
Kidney stones	☐	☐	_____
Kidney failure	☐	☐	_____
Were you born with any nervous system abnormalities?	☐	☐	_____
Brain disease	☐	☐	_____
Spinal cord disorder	☐	☐	_____
Nervous disease (MS, polio, etc.)	☐	☐	_____
Epilepsy	☐	☐	_____

	Yes	No	If yes, please explain
Stroke	☐	☐	_____
Diabetes	☐	☐	_____
Thyroid disorder	☐	☐	_____
Glaucoma	☐	☐	_____
Do you wear contacts?	☐	☐	_____
Stomach problems/Bowel problems	☐	☐	_____
Gallbladder problems	☐	☐	_____
Female: Do you have regular periods?	☐	☐	_____
Female: Are you going through menopause?	☐	☐	_____
Female: Are you pregnant?	☐	☐	_____
Female: Are you planning pregnancy preoperatively?	☐	☐	_____
Female: Have you breast fed in the past 3 months?	☐	☐	_____
Bridge work in mouth	☐	☐	_____
Crowns or dentures	☐	☐	_____
Loose teeth	☐	☐	_____
Problem opening mouth wide	☐	☐	_____
Problem turning head	☐	☐	_____
Do any diseases run in your family?	☐	☐	_____
Currently pregnant	☐	☐	_____
History of anaphylaxis	☐	☐	_____
History of multiple severe asthma	☐	☐	_____
History of cold sores	☐	☐	_____
Connective tissue disease i.e. RA, SLE	☐	☐	_____
History of immunosuppressive therapy	☐	☐	_____
Have you had an Aspirin or Motrin (NSAID) like medication in the last 2 weeks?	☐	☐	_____
Other	☐	☐	_____

Please list all medications (including aspirin, vitamins and over-the-counter medications) that you are presently taking. If none, write "none."

Name of Medication	Dosage	Reason for Taking

Please list allergies, if none, please write "none."

	Allergy	**Reaction**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Previous operations and approximate dates

Type of Operation: _____ _____ _____ _____

Approximate Date: _____ _____ _____ _____

Anesthetic Complications?_____ _____ _____ _____

Treating Doctor: _____ _____ _____ _____

Additional Infornation: _____ _____ _____ _____

	Yes	No	If yes, please explain
Blood transfusion	☐	☐	_____
Nausea or vomiting	☐	☐	_____
Allergic reaction to drug used in dental work	☐	☐	_____
Blood relative with serious allergy to anesthesia drug	☐	☐	_____
Allergic reaction to drug used with your surgery	☐	☐	_____
Latex allergy	☐	☐	_____
Have you ever had a blood clot in your legs or lungs?	☐	☐	_____
Do you have prolonged bleeding or trouble clotting your blood?	☐	☐	_____
Do you bruise easily?	☐	☐	_____

Additional medical history questions

	Yes	No	If yes, please explain
Have you ever had a complete physical in the last 12 months?	☐	☐	_____
Have you had and electrocardiogram in the last 12 months?	☐	☐	_____
Have you ever had a stress test?	☐	☐	_____
Who is your medical doctor? What city?	☐	☐	_____

Verification of Medical History

I completed and verified my above medical history as truly accurate to the best of my knowledge.

Patient Signature: _____ **Date:** _____