Cosmetic Surgical Arts & Rejuvenation of Oklahoma
12324 Saint Andrews Drive
Oklahoma City, OK 73120

**Patient Name:** **Date:**

# History and Physical

| Age____________________________ | Height__________________ | Weight___________________________ |
|---|---|---|

1) Patient Request:

2) Perceived or Real Deficiency:

3) Health History:
   Serious Illnesses:

   Surgery:

4) Medicines Taking:
   RX:

   OTC:

5) Allergies:

6) Bleeding:
   Aspirin:

   Ibuprofen:

7) Hx of Fever Blisters/Cold Sores YES NO

8) Is Patient a Smoker? YES NO

Physical Exam:

Date of Last Mammogram:___________________
N/A

Pos. Family Hx of Breast CA or Fibrocystic Disease
YES NO

How many
Children:______________________________

Are any more planned: YES NO

Pos. Breast Feeding: YES NO

Explanation of Procedure:

Complication Discussed in Full:

| | |
|---|---|
| Hematoma | Infection |
| Seroma | Wound Healing |
| Infection | Scars |
| Loss of sensation | Capular Contracture |

I have discussed the possible risks and of the procedure that the patient is seeking. I have also discussed the alternatives to this procedure and he possible risks and complications to these alternatives. I have answered all of the patient's questions. MAC

Actual Procedure to be performed:

1)____________________________________________________________________________

2)____________________________________________________________________________

3)____________________________________________________________________________

Time________**hours** **Local / General** **Labwork:**____________________________________