

**Todd C. Case, M.D., F.A.C.S.**  
Cosmetic Surgery Center

Thank you for choosing Dr. Case.

In order for us to more fully understand your need, we greatly appreciate you taking a moment to answer the following questions about your health and habits. Please answer each question to the best of your ability.

All information will be held in the strictest confidence.

**Health Questionnaire**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Social Security # \_\_\_\_\_

Work Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Person to notify in an emergency: \_\_\_\_\_

Phone: \_\_\_\_\_

1. Please list any operations you have had including minor or cosmetic surgery:

\_\_\_\_\_  
\_\_\_\_\_

2. Any reactions to anesthesia: \_\_\_\_\_

3. Please list any drugs or foods you are allergic to: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. Are you being treated for any medical illnesses? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

5. List any and ALL medications and or vitamins you are taking: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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6. Have you ever been treated for any of the following:

Asthma       Hepatitis       Heart Disease       Cold Sores  
 High Blood Pressure       Blood Clot       Eye Problems

7. Do you bleed or bruise easily? \_\_\_\_\_

8. Do you smoke? \_\_\_\_\_ or drink alcohol? \_\_\_\_\_

9. Do you form large scars? \_\_\_\_\_ use Accutane? \_\_\_\_\_

10. Do you diet? \_\_\_\_\_ or exercise? \_\_\_\_\_

How did you hear about us?  Website       Newspaper       Yellow Pages  
 Referring Physicians       Other

If you heard about us from a friend we would like to know their name so we can thank them.

\_\_\_\_\_

Please describe your daily skin care regimen: \_\_\_\_\_

\_\_\_\_\_

I am interested in learning about:

<input type="checkbox"/> Facial Skin Rejuvenation	<input type="checkbox"/> Facial Wrinkles / Laser
<input type="checkbox"/> Aging eyes / Eyelid surgery	<input type="checkbox"/> Aging Face / Face & Necklift
<input type="checkbox"/> Collagen / Botox	<input type="checkbox"/> Breast Implants / Breast Lifting
<input type="checkbox"/> Body contouring / Liposuction	<input type="checkbox"/> Tummy Tuck
<input type="checkbox"/> Nasal surgery	<input type="checkbox"/> Other: _____

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_