JORGE MENENDEZ, M.D., F.A.C.S.

Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

patient information

Aesthetic & Reconstructive Plastic Surgery
Certified by The American Board of Plastic Surgery
Fellow of The American College of Surgeons
Member of The American Society of Plastic Surgeons

Today's date	
Last Name	
First Name	
Date of Birth	
Age	
Referred By	
Reason for today's visit	
Social Security Number	
Home Phone	
Fax	
Cell	
Email	
Can we contact you by email?	Please check one
Yes	☐
No	☐
Your Street Address	
City	
State	
Zip Code	
Employer	
Type or Name of Business	
Position	
Employer Address	
Street	
City	
State	
Zip Code	
Work Phone	
Fax	
Email	
	Please check one
Male	☐
Female	☐

Marital Status	Please check one
Single	☐
Married	☐
Divorced	☐
Widowed	☐
Weight	
Height	
Brassiere Size	
Waist	
Personal Physician	
Physician's Phone	
Date of Last Physical Exam	
Date of Last Skin Exam	
Pregnant	Please check one
Yes	☐
No	☐
Date of Last Menstrual Period	
Birth Control Pills	Please check one
Yes	☐
No	☐
Other Birth Control	Please check one
Yes	☐
No	☐
Do you have children?	Please check one
Yes	☐
No	☐
How many?	
Did you breast feed your children?	Please check one
Yes	☐
No	☐

Were any of your children delivered by C-section?	Please check one
Yes	☐
No	☐
If yes, how many?	
Have you had a recent mammogram?	Please check one
Yes	☐
No	☐
Date	
Location	
Results	
Skin	
Do you visit a skin care salon on a frequent basis?	Please check one
Yes	☐
No	☐
Do you use skin care products?	Please check one
Yes	☐
No	☐
If yes, please list them.	
Do you routinely have any of the following skin therapies?	Please check all that apply
Microdermabrasion	☐
Acid Peels	☐
Laser Treatments	☐
Thermage	☐
Cool Touch	☐
Botox	☐
Collagen/other fillers (lips, lines, etc)	☐
Other	☐

How would you rate your skin health?	Please check one
Excellent	☐
Good	☐
Fair	☐
Need Skin Care	☐
Do you have a dermatologist?	Please check one
Yes	☐
No	☐
If yes, give dermatologist's name	
Do you wear makeup?	Please check one
Yes	☐
No	☐
Any Allergies to Medications?	Please check one
Yes	☐
No	☐
If yes, please list the medications and your reactions to them.	
Any Allergies to: Latex?	Please check one
Yes	☐
No	☐
Tape?	Please check one
Yes	☐
No	☐
Other substances or materials you are allergic to, please list them.	

Medications

Please list prescribed medications you are presently taking.	
Please list any over the counter medications you are presently taking.	
Please list any homeopathic, supplements or vitamins you are presently taking.	
Do you take Blood Thinners?	Please check one
Yes	☐
No	☐
Aspirin?	Please check one
Yes	☐
No	☐
Exercise	Please check one
Never	☐
Sometimes	☐
Moderate	☐
Aggressive	☐
Social History	
Smoke?	Please check one
Yes	☐
No	☐
Former	☐
Socially	☐
How many packs/day?	☐
How many years?	☐
Alcohol?	Please check one
Every day	☐
A few times a week	☐
Socially	☐
Never	☐
Drugs?	Please check one
Yes	☐
No	☐
Former	☐
Drug	☐
How long?	

Surgical History	
Any previous non-plastic surgery?	Please check one
Yes	☐
No	☐
Please list previous non-plastic surgeries and their dates if possible.	
Do you tend to form thick scars?	Please check one
Yes	☐
No	☐
Please select Plastic Surgery procedures you have had.	Please check all that apply
Botox Treatments	☐
Facelift	☐
Browlift	☐
Necklift	☐
Blepharoplasty (eyelid surgery)	☐
Rhinoplasty (nasal surgery)	☐
Ear surgery	☐
Lip Augmentation Surgery	☐
Lip Injections	☐
Chin Implant	☐
Breast Augmentation	☐
Breast Reduction	☐
Breast Lift	☐
Breast Reconstruction	☐
Liposuction Trunk	☐
Liposuction Arms/Legs	☐
Tummy Tuck	☐
Anesthesia History	
Any problems with anesthesia?	Please check one
Yes	☐
No	☐
If yes, please explain.	
Have you had Malignant Hyperthermia with anesthesia?	Please check one
Yes	☐
No	☐
Has any family member had a problem with Malignant Hyperthermia?	Please check one
Yes	☐
No	☐

Medical History

Please help us take better care of you by answering the following:

Condition:	Please check all that apply
Diabetes	☐
High Blood Pressure	☐
Chest Pain (at rest)	☐
Chest Pain (at exertion)	☐
Shortness of Breath	☐
Irregular Heartbeat	☐
Heart Murmur	☐
Heart Valve Problem	☐
Emphysema	☐
Heart Attack	☐
Bypass Surgery	☐
Asthma	☐
Stroke or loss of consciousness	☐
Seizures	☐
Facial Paralysis	☐
Bell's Palsy	☐
Vertigo	☐
Hearing Problems	☐
Thyroid Disease	☐
Easy brusing/excessive bleeding	☐
Gums bleed after brushing teeth	☐
Blood Clots	☐
Corneal Surgery (Lasik or similar)	☐
Cataracts	☐
Glaucoma	☐
Liver Disease	☐
Kidney Disease	☐
Ulcers (stomach, intestinal)	☐
Oral Herpes (cold sores)	☐
Vericose Veins	☐

Skin Disease	☐
Skin Cancer	☐
Abnormal healing (keloids, thick scars)	☐
Any of the following conditions:	
Breast Pain	☐
Breast Lumps	☐
Breast Cancer	☐
Cervical Cancer	☐
Ovarian Cancer	☐
Uterine Cancer	☐
Do you have any implants? (breast, joint/hip/knee, heart valve, dental or other)	Please check one
Yes	☐
No	☐
Please list them.	
I need antibiotics prior to dental work	Please check one
Yes	☐
No	☐
Do you wear eyeglasses?	Please check one
Yes	☐
No	☐
Do you wear contact lenses?	Please check one
Yes	☐
No	☐
Do you have dry eyes?	Please check one
Yes	☐
No	☐
Do you have any dietary restrictions?	Please check one
Yes	☐
No	☐

Family Medical History

Please check all that apply concerning your family history.

Condition	
Breast Cancer	☐
Cervical Cancer	☐
Uterine Cancer	☐
Ovarian Cancer	☐
Colon Cancer	☐
Melanoma	☐
Skin Diseases	☐
Birth Defects	☐
Would healing problems	☐
Blood Disorder	☐
Heart Disease	☐
Anesthesia (Malignant Hyperthermia)	☐
Diabetes	☐

Emergency Contact

Name	
Phone	
Fax	
Cell	
Email	
Relationship	

Other Contact

Name	
Phone	
Fax	
Cell	
Email	
Relationship	

Signature of Patient or Guardian

Date

Would you like to participate in a clinical research study that may help better treat your condition?

Please check one

Yes ☐

No ☐

Please visit us at our website at www.drmplasticsurgery.com

We also encourage you to visit the The American Society of Plastic Surgery at www.plasticsurgery.org

All Board Certified Plastic Surgeons can be found here as well as a wealth of information on Plastic Surgery.

Thank you for taking the time to visit with us.