COSMETIC SURGERY OF LAS VEGAS

MR#:

Pancholi

COSMETIC SURGERY
OF LAS VEGAS

DR SAMIR PANCHOLI

Please make every effort to fill out the information fully and accurately.
Your responses are held strictly confidential and are not shared.

Today's Date:

Name _____
First Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail _____

Preferred Method(s) of Contact: ❒ Home Phone ❒ Cell Phone ❒ Work Phone ❒ Email

Please do not contact me by: _____

Age _____ Birth Date _____ SS# _____ Gender ❒ Female ❒ Male

Height _____ Weight _____ Number of Children _____

Highest Level of Education ❒ High School ❒ Some College ❒ College ❒ Masters ❒ Doctorate

Marital Status: ❒ Married: Spouse's Name: _____ ❒ Single ❒ Separated/Divorced ❒ Widowed

If child, who may authorize treatment? _____ Relationship: _____

Contact: First Name _____ Last Name _____ Relationship _____

Home Phone _____ Cell Phone _____ Other Phone _____

Employer _____ Occupation _____

Address _____
Street & Suite # City State Zip

Spouse Employer _____ Occupation _____

Work Phone _____

Address _____
Street & Suite # City State Zip

Please indicate your area(s) of interest:

NON-SURGICAL	FACE	BREAST	BODY
❒ Latisse Eyelash Growth	❒ Eyes - Blepharoplasty	❒ Breast Enlargement	❒ Liposuction
❒ Botox	❒ Ears - Otoplasty	❒ Breast Implant Deflation	❒ Tummy Tuck
❒ Wrinkles	❒ Nose - Rhinoplasty	❒ Breast Implant Exchange	❒ Labiaplasty
❒ Skin Filler	❒ Facial Implant - Cheeks	❒ Breast Implant Correction	❒ Arm Reduction
❒ Lip Enhancement	❒ Facial Implant - Chin	❒ Breast Lift	❒ Brazilian Butt Lift
❒ Smile or Nasolabial Lines	❒ Forehead/Brow Lift	❒ Breast Reduction	
❒ Skin Care	❒ Facial Sculpting	❒ Male Breast Reduction	
❒ Obagi Blue Peel	❒ Necklift		
	❒ Facelift		
❒ Other	❒ Other	❒ Other	❒ Other

Please use this space to provide any other information you feel may be helpful to your consultation:

Have you been educated about these procedures with other Surgeons? ❒ Yes ❒ No

Procedure _____ Doctor _____ How long ago? _____
Procedure _____ Doctor _____ How long ago? _____
Procedure _____ Doctor _____ How long ago? _____
Procedure _____ Doctor _____ How long ago? _____

How did you hear about Dr. Pancholi? (Mark all that apply)

❒ www.drpancholi.com _____ ❒ Billboard: _____
❒ Email Promotion: _____ ❒ Business: _____
❒ Website: _____ ❒ Phonebook: _____
❒ Magazine: _____ ❒ Newspaper: _____
❒ Event: _____ ❒ Facebook: _____
❒ General Reputation _____ ❒ Other: _____
❒ Friend/Relative: ❒ Doctor:

Medical History

Your medical history is an extremely important part of your consultation. It helps alert us to any potential conditions that may interfere with your surgery. Please take your time and fill this out as completely and accurately as possible. If you need any help or have questions, our staff will be happy to assist you.

List **All Prescription and *Non Prescription*** medications you are taking:

List any **Medical Conditions** you have or had:

List any **Surgery** you have had (including Cosmetic Surgery) **with dates**:

List any serious **Major Illness / Injury** you have had in the past:

List any **Diet Pills** you take (May cause problems with anesthesia):

List any **Drug Allergies**:

List any **Contact Allergies** (latex or other products):

Describe any difficulties you have had with **anesthesia**:

List any hereditary disorders that run in your family:

Breast Cancer Family History: Do you have/had:

- ❒ 2 or more relatives with breast cancer
- ❒ 2 or more relatives with ovarian cancer
- ❒ A relative with both breast and ovarian cancer
- ❒ A male relative with breast cancer
- ❒ A relative who got breast cancer before age 50
- ❒ An Ashkenazi Jewish heritage relative with breast or ovarian cancer

Do you Smoke? ❒ No ❒ Yes: What? _____ How many per day? _____ How many years? _____

Do you drink Alcohol? ❒ No ❒ Occasionally ❒ 1-2 drinks daily ❒ 3 or more drinks daily

Do use any Recreational Drugs?

❒ No ❒ Yes: What? _____ Times a Week? _____ How Many Years? _____

Do you or have you ever had an addiction to narcotics or recreational drugs?

❒ No ❒ Yes: What? _____ Duration of use? _____ Date of last use: _____

How do you rate your general health? ❒ Poor ❒ Fair ❒ Good ❒ Excellent

Are you under a doctor's care? ❒ No ❒ Yes: Doctors First and Last name: _____

Review the list below and check all applicable. If you check any box, use the space below to explain further if needed.

- ❒ Chronic Skin condition
- ❒ Severe dryness of the eyes
- ❒ Glaucoma or blurry vision
- ❒ Wear Glasses/Contacts
- ❒ Drainage from ears
- ❒ Difficulty Hearing
- ❒ Ringing in Ears
- ❒ Recurrent severe dizziness
- ❒ Nasal Injury
- ❒ Frequent Nose bleeds
- ❒ Difficulty Breathing from Nose
- ❒ Difficulty Smelling
- ❒ Chronic Sinus Infections
- ❒ Frequent Nasal Allergies
- ❒ Chronic sinus/nasal blockage
- ❒ Difficulty with Taste
- ❒ Recurrent fever blisters
- ❒ Severe headaches
- ❒ Head Injury
- ❒ Paralysis (Face or Body)
- ❒ Shortness of breath
- ❒ Sleep on pillows to help breathing
- ❒ Asthma or emphysema
- ❒ Coughing up blood
- ❒ Lung disease
- ❒ Chronic hoarseness
- ❒ Heart Attack
- ❒ Heart disease
- ❒ Racing heart rate without cause
- ❒ High Blood Pressure
- ❒ Chest pain
- ❒ Swollen legs and ankles
- ❒ Stroke
- ❒ Cancer
- ❒ Abnormal lump
- ❒ Enlarged lymph node
- ❒ Unexplained weight loss
- ❒ Problems with bones or joints
- ❒ Arthritis
- ❒ Joint Disease
- ❒ Acid Reflux
- ❒ Stomach ulcers
- ❒ Chronic Abdominal problems
- ❒ Yellow Jaundice or Hepatitis
- ❒ Blood in Bowel movements / Stool
- ❒ Kidney or bladder problems
- ❒ Blood in Urine or trouble urinating
- ❒ Bleeding disorders (you or family)
- ❒ Blood clots (you or family)
- ❒ Menstrual disorder
- ❒ Easy bruising
- ❒ Anemia
- ❒ Altered Thyroid hormone levels
- ❒ Diabetes
- ❒ Low blood sugar
- ❒ Always thirsty or urinating
- ❒ Sensation changes
- ❒ Treated/Tested positive for Tuberculosis
- ❒ Treated/Tested positive for HIV
- ❒ Treated/Tested positive for AIDS
- ❒ Treated/Tested positive for Hepatitis
- ❒ Hospitalized for mental illness
- ❒ Emotional/Psychological concern
- ❒ Under Psychiatric care
- ❒ Alcoholism / Drug Addictions
- ❒ Complications after surgery
- ❒ Bad/ unsatisfactory surgical outcome
- ❒ **NONE OF THE ABOVE**
- ❒ Other: _____

Please explain:

I understand that I am responsible for all bills to be paid in a timely manner and that this contract is between Dr. Pancholi and myself. **I have read this form entirely and have completed it fully and accurately to the best of my knowledge.**

Patient Signature _____ **Date**

Dr. Pancholi Signature **Date Reviewed**