LOMBARDO
COSMETIC SURGERY

Date: _____ Home Phone: _____

Name: _____ Cell Phone: _____

I would like text message confirmations: Yes _____ No _____ **Initials**: _____

Age: _____ **Birthdate:** _____ Gender: M F Marital Status: S M D W

Email Address: _____

Mailing Address: _____City/State: _____ Zip: _____

Occupation: _____ Employer Name: _____

Business Address: _____ City/State _____ Zip _____

EMERGENCY Contact: _____ Phone:_____Spouse/Parent/Relative

What is the reason for your visit today? _____

Who may we thank for referring you? _____

How did you hear about us? **Please check all that apply:**

□ **Facebook** □**Internet** □ **Google Search** □ **Lombardo Cosmetic Surgery Website** □ **Billboard**

□ **CV Weekly** □ **YELP** □ **Gay Desert Guide** □ **Friend or Family**

□ **Physician Referral (name:_____)** □ **Other (please list:_____)**

What additional services would you like to learn about? Please check all that apply…

□ Botox™	□ Length/fullness of eyelashes	□ Breast size
□ Facial Fillers (Juvederm™, Voluma™, Restylane™, Scultpra™, Bellafill™)	□ Facial fullness/drooping	□ Abdominal area
□ Latisse™	□ Chemical Peel	□ Hips
□ SkinMedica™ skin care products	□ Brown spots/age spots/freckles	□ Legs
□ Facial fine lines/wrinkles	□ Drooping eyelids	□ Arms
□ Crow's feet area	□ Weight loss	□ Body contouring
□ Frown lines area	□ hCG diet program	□ Scar revision
		□ Would you like to learn more about taking good care of your skin?

Do you have a primary care physician?: **Y N**

Doctor's Name: _____
Location: _____

Are you taking any Medications? **Y N**
Please List Names & Doses: _____

_____

Are you taking any blood thinning medications? **Y N**
Circle all that apply:
Aspirin, Aleve, Ibuprofen, red wine, turmeric, fish oil
Other: _____

Are you taking Vitamins or Herbal Supplements: **Y N**
Please list Names: _____

_____

Do you bleed excessively after a cut, wound or surgery? **Y N**

Have you had previous surgery? **Y N**
List operations: _____

_____

_____

Do you have any Allergies/Sensitivities to Medications? **Y N**
Please list drug & reaction: _____

_____

Please check if you currently have or have had any of these conditions:

□ Asthma
□ Anemia
□ Anesthesia related problems
□ Anxiety/depression
□ Arthritis
□ Back/Neck pain
□ Bleeding problems
□ Blood Clots
□ Cancer
□ Chest Pain
□ Chronic Cough
□ Chronic Pain
□ Diabetes
□ Emphysema
□ Glaucoma
□ Heartburn
□ Herpes Infection/ *Cold Sores*
□ Heart Disease/Murmur
□ High Blood Pressure
□ HIV/AIDS
□ Hepatitis
□ Latex Allergy
□ Liver Disease
□ Jaundice
□ Joint Replacement
□ Kidney Disease
□ Lung Disease
□ Nervous Breakdown
□ Pacemaker
□ Seizures
□ Stroke
□ Stomach Ulcers
□ TB/Tuberculosis
□ Thyroid Disease

□ Other:

_____

Habits:
□ I smoke cigarettes or cigars _____ per day □ I use e-cigarettes _____ per day □I use caffeine _____ per day
□ I drink alcoholic beverages _____ per week □ I drink more than 10 alcoholic beverages per week

I AUTHORIZE Dr. Maria Lombardo to examine and provide Medical/Surgical Treatment. I will not record, in any way, anything which occurs in the office of Dr. Lombardo without the prior written consent of Dr. Lombardo. I AGREE that I am responsible for the professional services rendered by Lombardo Surgical, Inc. & Lombardo Cosmetic Surgery. I also authorize this office to release any information necessary to process this claim.

Signature: _____ Date: _____

OFFICE USE: ☐**TY** ☐ **E-Mail Date** _____