CHUA PLASTIC SURGERY

Consultation Form

(Shaded areas are for office use only)

Nombre:_____ Fecha de nacimiento:_____ Edad:_____ Género:___

Dirección: _____ Ciudad:_____ Estado: _____ Zip: _____

Numero de telefono:_____ Correo Electrónico:_____

Altura: _____ Pesos: _____ Ocupación: _____

Contacto de emergencia: _____ Numero de telefono de emergencia: _____

Doctor Primaria: _____ Última vez que fuiste al doctor: _____

Razon de Consulta ¿Qué fecha estaba pensando en hacerte esta cirugía? _____	☐ Abdominoplastia (Tummy tuck)	☐ Brazilian Butt Lift
	☐ Aumento de senos	☐ Levantamiento de senos
	☐ Liposuction (which areas) _____	☐ Other: _____

Past Medical History - Have you had or currently have any of the following:

Alta presion	▢ Yes ▢ No	Von Willebrand	▢ Yes ▢ No	Problemas de riñon	▢ Yes ▢ No
Alta cholesterol	▢ Yes ▢ No	Factor V Leiden	▢ Yes ▢ No	Problemas hepáticos	▢ Yes ▢ No
Asma	▢ Yes ▢ No	G6PD Deficiency	▢ Yes ▢ No	Hepatitis	▢ Yes ▢ No
Diabetes Type 1	▢ Yes ▢ No	Sickle Cell Disease	▢ Yes ▢ No	Chlamydia	▢ Yes ▢ No
Diabetes Type 2	▢ Yes ▢ No	Sickle Cell Trait	▢ Yes ▢ No	Gonorrhea	▢ Yes ▢ No
Enfermedad del corazón	▢ Yes ▢ No	Embolia pulmonar	▢ Yes ▢ No	HIV/AIDS	▢ Yes ▢ No
Anemia	▢ Yes ▢ No	Deep Vein Thrombosis	▢ Yes ▢ No	Problemas del estomago	▢ Yes ▢ No
COPD	▢ Yes ▢ No	Wolff Parkinson White	▢ Yes ▢ No	Dolor crónico	▢ Yes ▢ No
Cancer	▢ Yes ▢ No	Problemas de coagulación	▢ Yes ▢ No	Ataque al corazón/stroke	▢ Yes ▢ No
Insuficiencia cardiaca	▢ Yes ▢ No	Malignant Hyperthermia	▢ Yes ▢ No	Problemas psiquiátricos	▢ Yes ▢ No

Women Only:

Social History

¿Estás embarazada o podrías estarlo?	▢ Yes ▢ No				How much/often?
			Nicotine	▢ Yes ▢ No	
¿Estás amamantando?	▢ Yes ▢ No		Alcohol	▢ Yes ▢ No	
¿Está tomando alguna forma de	▢ Yes ▢ No		Drogas recreativas	▢ Yes ▢ No	

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control de la natalidad?					

Antecedentes familiares (enumere todas las enfermedades hereditarias o enfermedades raras que se le hayan diagnosticado a alguien):

_____

¿Problemas anteriores con la anestesia en el paciente o la familia? ▢ Si ▢ No

Historial quirúrgico anterior (enumere todas las cirugías que haya tenido, ya sean necesarias o electivas):

_____

_____

Medicamentos	Vitaminas/Suplementos	Alergias		En caso afirmativo, ¿cuál es la reacción?
		Latex	▢ Yes ▢ No	
		Penicillin	▢ Yes ▢ No	
		Sulfa	▢ Yes ▢ No	
		Iodine	▢ Yes ▢ No	
		Other		

Measured Height _____ Measured Weight _____	Calculated BMI _____
Itemized Procedure Requested	Itemized Quote Given
	Discounts/Specials:
	Total Quote:
Surgery Date Requested:	Doctor Consultation Date:
Special Notes:	

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▢ Medical clearance	▢ Labs	▢ Photos	▢ Consultation Fee
Initial Consult By:			

Chua Plastic Surgery
IG:chuaplasticsurgery
P: 725-529-2482

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Statement of Non-Solicitation

I, _____(patient name) hereby state that I came to Chua Plastic Surgery of my own free will and volition. Neither Dr. Charleston Chua, nor anyone employed by Chua Plastic Surgery, solicited, marketed, induced, contacted, or otherwise reached out to me by any means prior to my initial contact and consultation with Chua Plastic Surgery on _____(date). I was a patient of Dr. Charleston Chua prior to this initial consultation at a different surgical practice. Notwithstanding my prior patronage of that other surgical practice, I chose to exercise my free will and seek out Dr. Charleston Chua at Chua Plastic Surgery to perform my requested procedure(s). I further attest that I was not asked, coerced, or paid by any person, company, or associate thereof to seek out Dr. Charleston Chua at Chua Plastic Surgery for the purpose of reporting information back about the practice.

_____ _____

Patient or Person Authorized to Sign for Patient Date