UNIVERSITY OF IOWA HEALTH CARE | *Aesthetic Consultants of Iowa*
PLASTIC AND RECONSTRUCTIVE SURGERY

3705 River Ridge Dr. N.E.
Cedar Rapids, IA 52402
319-393-1902 Tel
319-393-1867 Fax
www.lookmybestnow.com, www.realself.com, or
www.uihealthcare.org/plastic-and-reconstructive-surgery

Name _____ DOB _____ Age____ Social Security #_____

Mailing Address_____
Street / PO Box City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Occupation: _____ If retired, previous occupation: _____

Who Recommended This Consultation?

- ☐ Doctor_____
- ☐ Friend/Former Patient_____
- ☐ Other_____
- ☐ Internet
  - ☐ www.lookmybestnow.com
  - ☐ www.uihealthcare.org/plastic-and-reconstruction-surgery
  - ☐ www.realself.com

Is this a WORK or AUTO ACCIDENT related injury: ☐ YES ☐ NO Date of Injury if accident related: _____

Please list below the names and address of any Physicians you would like to receive a copy of today's evaluation (other than the physician who referred you).

Name	Address *(if known)*

What problem are you having that brought you here today?

_____

_____

Are you currently having any pain? Please circle a number below to rate your pain:

0 1 2 3 4 5 6 7 8 9 10

No Pain ⟶ Moderate Pain ⟶ Severe Pain

Please list your medication below.
Include aspirin, herbals, eye drops, vitamins, and all over-the-counter medications

MEDICATION NAME	DOSE (How many milligrams?)	FREQUENCY (How many time per day?)

Please list any allergies (medication/environmental/food)

ALLERGIC TO	TYPE OF REACTION

Provider Reviewed _____

Please list any previous surgery

DATE (Approximate)	TYPE OF SURGERY	HOSPITAL

Do you smoke cigarettes? ☐ Yes ☐ No If yes, how many packs per day. _____ How many years. _____

☐ Quit smoking _____ (Number) years/days (Please Circle) ago. ☐ Never smoked

Please check any other tobacco products you use: ☐ cigars ☐ pipe tobacco ☐ chew tobacco

Do you drink alcohol? ☐ Yes ☐ No If yes, what type: _____. How often: _____

Do you use any recreational or street drugs? ☐ Yes ☐ No If yes, what type: _____. How often: _____

Family Medical History

☐ Cancer ☐ COPD or Asthma ☐ Heart Disease ☐ High Blood Pressure or Stroke ☐ Kidney Disease ☐ Other

Personal Medical History (please check all that apply to you now or in the past)

Cardiovascular:

Yes No

- ☐ ☐ Rheumatic fever
- ☐ ☐ Heart murmur
- ☐ ☐ Palpitations
- ☐ ☐ Irregular heart beat
- ☐ ☐ Chest pain
- ☐ ☐ Heart attack
- ☐ ☐ High blood pressure
- ☐ ☐ Heart failure
- ☐ ☐ High cholesterol
- ☐ ☐ Stroke / Mini stroke (TIA)
- ☐ ☐ Blood clots (DVT)
- ☐ ☐ Pulmonary emboli
- ☐ ☐ Varicose veins
- ☐ ☐ Pain in legs with walking
- ☐ ☐ Bruising / bleeding tendency
- ☐ ☐ Aneurysms

Respiratory:

Yes No

- ☐ ☐ Asthma
- ☐ ☐ Wheezing
- ☐ ☐ Emphysema
- ☐ ☐ COPD
- ☐ ☐ Chronic cough
- ☐ ☐ Tuberculosis
- ☐ ☐ Sleep apnea (stop breathing during sleep)
- ☐ ☐ Oxygen use
- ☐ ☐ Lung cancer

Gastrointestinal:

Yes No

- ☐ ☐ Stomach ulcers
- ☐ ☐ Gastric reflux / heartburn
- ☐ ☐ Hepatitis (specify A, B, C)
- ☐ ☐ Liver disease
- ☐ ☐ Blood in stool
- ☐ ☐ Black (tarry) stool
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Change in bowel movements
- ☐ ☐ Abdominal pain
- ☐ ☐ Nausea / Vomiting
- ☐ ☐ Crohns disease
- ☐ ☐ Irritable bowel syndrome
- ☐ ☐ Ulcerative colitis
- ☐ ☐ Colon cancer

Genitourinary:

Yes No

- ☐ ☐ Frequent urination
- ☐ ☐ Nighttime urinary frequency
- ☐ ☐ Burning with urination
- ☐ ☐ Blood in urine
- ☐ ☐ Lack of bladder control
- ☐ ☐ Weak urine stream
- ☐ ☐ Urinary tract infections
- ☐ ☐ Kidney stones
- ☐ ☐ Kidney failure
- ☐ ☐ Enlarged prostate
- ☐ ☐ Prostate cancer
- ☐ ☐ Bladder cancer
- ☐ ☐ Kidney cancer
- ☐ ☐ Testicular cancer
- ☐ ☐ Erectile dysfunction

Other:

Yes No

- ☐ ☐ Sexually transmitted Disease STD
- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Chronic fatigue
- ☐ ☐ Fibromyalgia
- ☐ ☐ Arthritis
- ☐ ☐ Degenerative arthritis
- ☐ ☐ Rheumatoid arthritis
- ☐ ☐ Glaucoma
- ☐ ☐ Thyroid disease
- ☐ ☐ Hyperthyroid
- ☐ ☐ Hypothyroid
- ☐ ☐ Goiter
- ☐ ☐ Thyroid cancer
- ☐ ☐ HIV / AIDS
- ☐ ☐ Diabetes
- ☐ ☐ Steroid use
- ☐ ☐ Skin Cancer
- ☐ ☐ Headaches
- ☐ ☐ Weight loss
- ☐ ☐ Food allergies

DEPRESSION / ANXIETY

Have you ever been treated for depression or anxiety?

Physician: _____

Medications: _____

Hospitalization: _____

Provider Reviewed _____

UNIVERSITY OF IOWA HEALTH CARE | *Aesthetic Consultants of Iowa* PLASTIC AND RECONSTRUCTIVE SURGERY

Facial Injections

Name _____ **DOB:**_____ **Date**_____

What areas of your face are you most interested in treating?:_____

_____

Why are you considering injections now?:_____

What are your current facial skin care products?:_____

_____

FACIAL INJECTIONS HISTORY

Have you ever had any Dermal injections? Yes / No
If yes, please list last treatment date, and areas treated.

_____

_____

Were you satisfied with the results?

_____

Have you ever had any Botox injections? Yes / No
If yes, please list last treatment date, and areas treated.

_____

_____

Were you satisfied with the results?

_____

Have you ever had eyelid or eyebrow droop after Botox? Yes / No
Do you ever have eyelid droop during the day or at the end of the day? Yes / No

Have you ever had surgery to the face/neck? Please list.

_____

_____

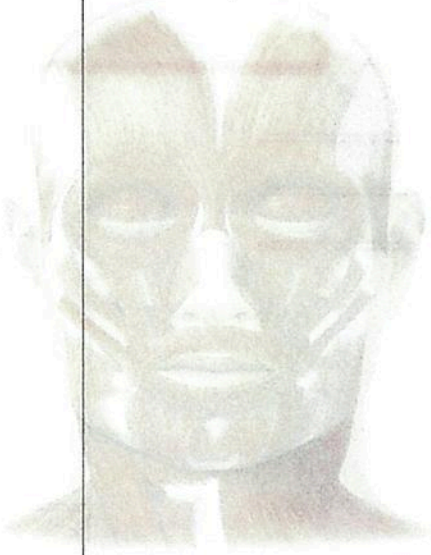
Any Personal History of the following?

Yes	No	
☐	☐	Bleeding disorder / Easy bruising
☐	☐	Allergy to Beef/Dairy/Cow's milk products
☐	☐	Allergy to Lidocaine
☐	☐	Neurologic disorder
☐	☐	Myasthenia gravis
☐	☐	Lambert-Eaton Syndrome
☐	☐	Keloid scarring
☐	☐	Current use Clindamycin / Gentamicin
☐	☐	Current use Donepezil (Aricept)
☐	☐	Current use physostigmine (Eserine) eye drops
☐	☐	Accutane use within the last 1 year
☐	☐	Pregnant, Trying to get pregnant, or Nursing
☐	☐	History of Cold Sores
☐	☐	Herbal Supplement use (Please list)

Patient Signature:

_____

****



Provider Reviewed _____

UNIVERSITY OF IOWA HEALTH CARE | *Aesthetic Consultants of Iowa* PLASTIC AND RECONSTRUCTIVE SURGERY

Injection Chart

Name _____ **DOB:**_____ **Date**_____

Botox Dilution Used

	Saline	Unit Vial	# Units/0.1ml
○	2 cc	100 U vial	5 U/0.1ml
○	1 cc	50 U vial	5 U/0.1ml
○	4 cc	100 U vial	2.5 U/0.1ml
○	2 cc	50 U vial	2.5 U/0.1ml
○	5 cc	50 U vial	1 U/0.1ml

Medication Information

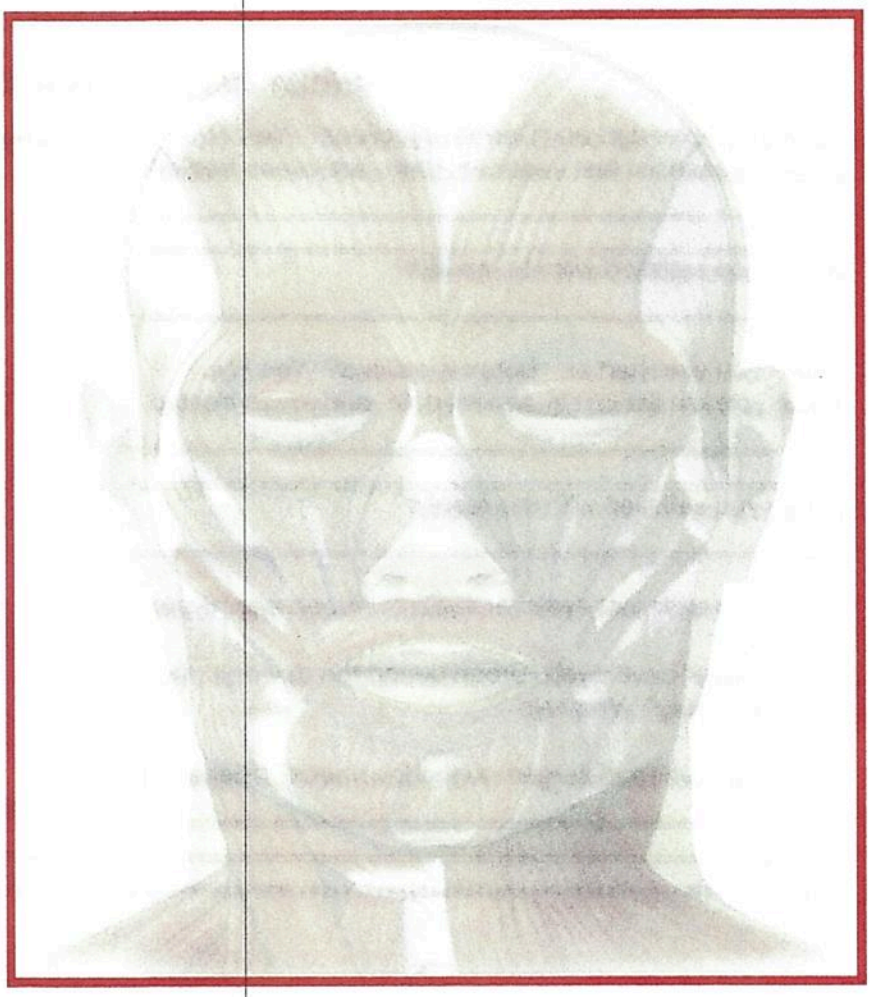
_____

Lot Number

_____

Expiration Date

Place Label Here



Total Units (Forehead) _____

Total Units (Glabellar) _____

Total Units (Crows Feet) _____(R) _ _____(L)

Total Units (Other Area) _____

TOTAL UNITS = _____

_____

_____

_____

_____

Physician Signature