Aesthetic Consultants of Iowa
PLASTIC AND RECONSTRUCTIVE SURGERY

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Cedar Rapids, IA 52402
*319-393-1902 **Tel***
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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 ago. (Please Circle) ☐ 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

Breast Form

Name ______________________ **DOB:**__________ **Date**__________

Height:________ Weight:________ Months at current weight?________ Bra size:________
Why are you considering surgery now?:______________________
What are your expectations/desires from surgery?:______________________
____
Activity Level:______________________ Planning any weight loss?: Yes / No

BREAST HISTORY

Last menstrual period:______________________
Age at first period:______________________
Number of children:______________________
Ages of children:______________________
Did you breast feed your children? Yes / No
Plan on having more children? Yes / No
Method of current birth control?______________________
Date of last mammogram:______________________
Findings on last mammogram:______________________

Any previous breast surgery or biopsies (dates/findings)?
____
____
Do you do monthly breast self-examinations? Yes / No
Any breast changes that concern you? Yes / No

Any history of breast cancer in your family?
If yes, please list approximate age of onset.

Yes	No	
☐	☐	Mother
☐	☐	Maternal grandmother
☐	☐	Maternal aunt
☐	☐	Sister
☐	☐	Daughter
☐	☐	Paternal grandmother
☐	☐	Paternal aunt
☐	☐	Any male member of your family
☐	☐	BRCA positive family member

Patient Signature:
____

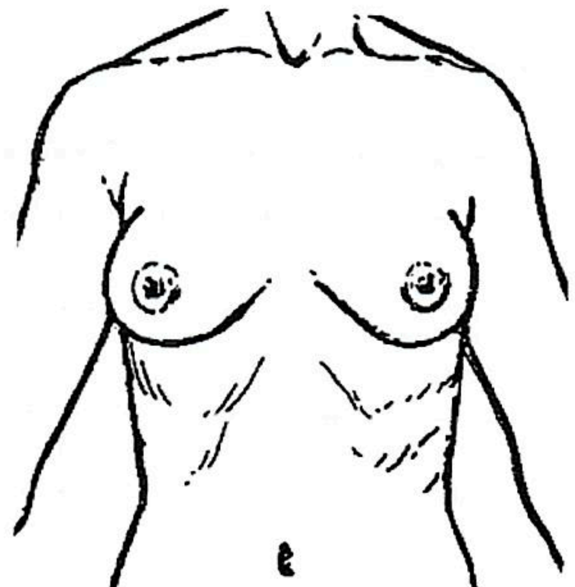
****

FOR PHYSICIAN USE ONLY

Size: R=L R < L R > L Skin: Tight Straie
Inframammary crease: R=L R>L R<L

GRAMS TO BE REMOVED: RIGHT SIDE__________ **LEFT SIDE**__________

ICD9	ICD 10	
611.1	N62	breast hypertrophy
782.1	R21	rash & other nonspecific skin eruption
695.89	L30.4	intertrigo
724.1	M54.6	pain in thoracic spine
724.5	M54.9	back pain, unspecified
723.1	M54.2	pain in neck
719.41	M25.519	pain in shoulder region
782.2	R22.9	shoulder grooving



PLAN:

Provider Reviewed ________

Breast Reduction

Patient Name:____ Date of Birth:______________

____Back Pain – Duration _______ (years/months/days)

Treatment____

____

By Whom: ____

____Shoulder Pain – Duration_____(years/months/days)

Treatment____

____

By Whom____

____Neck Pain – Duration_______(Years/months/days)

Treatment____

____

By Whom____

______Rashes underneath/between breasts – Duration_____(years/months/days)

Treatment____

____

By Whom____

____Shoulder grooving? Duration__(years/months/days)

Treatment____

____

By Whom____

Activities of Daily Living you are unable to do because of breast size____

____

Additional problems/info____

____

____

____

Provider Reviewed ________