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 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 _____

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

Gynecomastia

Name _____ *DOB:*_____ *Date*_____

Height:_____ Weight:_____ Months at current weight?_____ Activity Level:_____

Areas of concern:_____

What changes in this area concern you:_____

At what age first noticed:_____

Do you have any pain in this area?_____ Please circle area affected: Both sides/right side/left side.

Is there any history of breast cancer in your family?_____. If so, what relation_____

Do you have a personal history of the following:

Yes	No	
☐	☐	Pain / Masses of Testicles
☐	☐	Previous breast surgeries
☐	☐	Testicular tumor
☐	☐	Adrenal tumor
☐	☐	Personal use of anabolic ateroids
☐	☐	Personal use of estrogen
☐	☐	Personal use of growth hormone
☐	☐	Personal use of marijuana
☐	☐	History of obesity
☐	☐	Hyperthyroidism
☐	☐	Liver disease or cirrhosis
☐	☐	Chronic kidney disease
☐	☐	HIV
☐	☐	Klinefelter's syndrome

Have you ever used the following medications:

Yes	No	
☐	☐	Finasteride
☐	☐	Spironolactone
☐	☐	Ketoconazole
☐	☐	Metronidazole
☐	☐	Isoniazid
☐	☐	Ranitidine
☐	☐	Methotrexate
☐	☐	Digoxin
☐	☐	Verapamil
☐	☐	Diltiazem
☐	☐	Amiodarone
☐	☐	Enalapril
☐	☐	Diazepam
☐	☐	Antipsychotic medications
☐	☐	Metoclopramide
☐	☐	Phenytoin
☐	☐	Statins

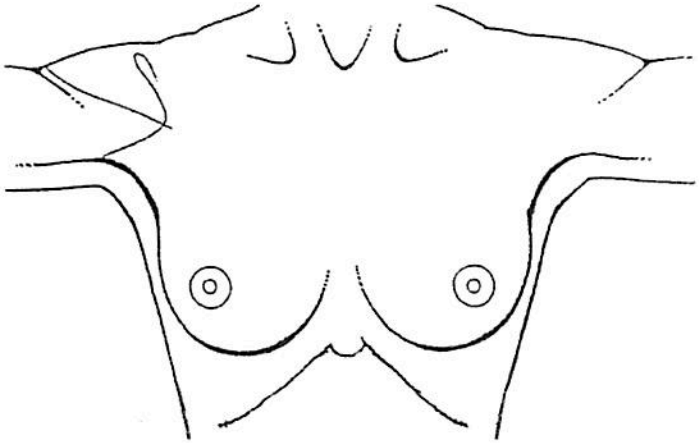
****

FOR PHYSICIAN USE ONLY

Size: R=L R < L R > L Skin: Tight Strale

Inframammary crease: R=L R>L R<L

Grade I: Small breast enlargement, localized button of tissue around the areola.
Grade II: Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest.
Grade III: Moderate breast enlargement exceeding areolar boundaries with edges that are distinct from the chest with skin redundancy.
Grade IV: Marked breast enlargement with skin redundancy and feminization of the breast.



Provider Reviewed _____