

**Arizona Center for Aesthetic Plastic Surgery**  
**Steven H. Turkeltaub, M.D., P.C.**  
*Certified, American Board of Plastic Surgery*

**Please complete all items and print**

Date \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

How were you referred here? Internet \_\_\_\_\_ Yellow Pages \_\_\_\_\_ Physician \_\_\_\_\_ Patient \_\_\_\_\_ Family \_\_\_\_\_ Friend \_\_\_\_\_ Insurance \_\_\_\_\_  
Self \_\_\_\_\_ ASPS \_\_\_\_\_ Other \_\_\_\_\_ None \_\_\_\_\_ Name of Referral or Website \_\_\_\_\_

**PLEASE DESCRIBE THE REASONS FOR YOUR CONSULTATION.** (Include all relevant information)

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**MEDICAL HISTORY**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Ideal weight \_\_\_\_\_ Have you been trying to lose weight? Yes \_\_\_\_\_ No \_\_\_\_\_  
Any weight loss? Yes \_\_\_\_\_ No \_\_\_\_\_ How much? \_\_\_\_\_ Over what period of time? \_\_\_\_\_

Have you ever smoked? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, do you still smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ How many packs per day? \_\_\_\_\_

At what age did you start? \_\_\_\_\_ At what age did you stop? \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ What and how much? \_\_\_\_\_

Do you use recreational drugs? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, drug and frequency \_\_\_\_\_

Have you ever had Hepatitis? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when? \_\_\_\_\_

Do you have AIDS or are you at high risk for acquiring AIDS? Yes \_\_\_\_\_ No \_\_\_\_\_

Will you have an AIDS test if surgery is planned? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had anesthesia previously? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, any problems? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what? \_\_\_\_\_

**PREVIOUS COSMETIC PROCEDURES** (Please list)

Operation	Year	Surgeon's Name
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**(continued - please complete the back side of this form)**

**OTHER PREVIOUS SURGICAL PROCEDURES** (Please list)

Operation

Year

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**MEDICAL ILLNESSES**

Type

Treatment, if any:

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**MEDICATIONS** (List all medications and dosages including pain relievers, aspirin, birth control pills and steroids.)

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Do you have allergies to any medications? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list below:

Name of medication

Type of Reaction

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**SYSTEM REVIEW**

Have you had problems with any of the following? (If yes, check which ones.)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abnormal scars or keloids | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Liver Problems                 |
| <input type="checkbox"/> Burning eyes              | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Yellow Skin                    |
| <input type="checkbox"/> Blurred/Double Vision     | <input type="checkbox"/> Palpitations           | <input type="checkbox"/> Burning when urinating         |
| <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Numbness and tingling in hands |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Arthritis                      |
| <input type="checkbox"/> Nose Bleeds               | <input type="checkbox"/> Bleeding Problems      | <input type="checkbox"/> Seizures                       |
| <input type="checkbox"/> Sinus Problems            | <input type="checkbox"/> Stomach Pain           | <input type="checkbox"/> Emotional/psychiatric problems |
| <input type="checkbox"/> Shortness of Breath       | <input type="checkbox"/> Stomach/Duodenal Ulcer |   |

**MATERNAL HISTORY** (Women)

Have you ever been pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ How many times? \_\_\_\_\_ Number of children \_\_\_\_\_

Are you pregnant now? Yes \_\_\_\_\_ No \_\_\_\_\_ Are you planning more children? Yes \_\_\_\_\_ No \_\_\_\_\_

**FAMILY HISTORY**

Diabetes \_\_\_\_\_ Skin Cancer \_\_\_\_\_ Breast Cancer \_\_\_\_\_ Problems with anesthesia \_\_\_\_\_ Bleeding problems \_\_\_\_\_