PLASTIC SURGERY
ENVY Aesthetic Center

Lyle D. Weeks M.D.

Confidential Patient Profile

****Please complete this form carefully****

Date_____

First Name_____M.I.____Last Name_____

SSN____-___-____ Date of Birth____/____/_____ Age_____ Gender_____
(Month) (Day) (Year)

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____

Email address_____

Can you receive important information & correspondence at the address listed above from this office? (Yes)__ (No)__

Emergency Contact_____ Phone #_____Relationship_____

How did you hear about us? Friend or Relative__(Name)_____ Physician (Name)_____
Newspaper_____ Yellow Pages_____ Radio___ Television_____Internet_____ Website_____
Other source_____

HEALTH QUESTIONNAIRE

If "YES", please list date of problem

Heart	NO__ YES_____	Prior Problems with Anesthesia	NO__ YES_____
Blood Pressure	NO__ YES_____	History of Cancer	NO__ YES_____
Diabetes	NO__ YES_____	Pregnant NO__ YES_____	Breastfeeding_____
Bleeding Problems	NO__ YES_____	Neuromuscular Disease	NO__ YES_____
		Other_____	

Smoker NO__ YES__ Allergic to:_____

Current Medications:_____

_____

Height:_____ Weight:_____ Family/Physician/Specialist Treating you NO__ YES__ For what condition?_____

_____

What cosmetic procedures are you interested in and/or concerned about? *Please check all that apply.*

Fat Transfers__	Laser – Fraxel (skin resurfacing)__	Breast Augmentation__
Facial Peels__	Laser – Cool Touch/V-Beam__	Breast Reduction__
Botox Injections__	Laser – Hair Removal__	Breast Reconstruction__
Injectable Fillers__	Laser – Vein Therapy__	Tummy Tuck (Abdominoplasty) __
Facelift/Neck lift/ Chin Liposuction__	Laser – Tattoo Removal__	Liposuction__
Eyelid Surgery__Upper/Lower	Thermage (Skin Tightening)__	Other Body Contouring__
Nasal Refinement__	CoolSculpting (Contouring Treatment)__	Chin Implants__
Lip Augmentation (Injections/Implants)__	Ear Reconstruction__	Skin Care__

Other Procedures_____