Randy J. Buckspan, MD, FACS

Welcome to the office of Randy J. Buckspan, MD, FACS. Our goal is to provide you personalized service before, during and after your procedure. Dr. Buckspan and his staff understand how a change in your appearance, whether it is subtle or dramatic, can improve self-image by helping you feel more confident and comfortable with the way you look. Please take a few minutes to answer the following questions so we may begin to develop a personal cosmetic enhancement program just for you. We are dedicated to meeting your needs and making this a very pleasant experience.

PATIENT INFORMATION

Name: ____Age: ________ Birthdate: ________________

Address: ____ Telephone: _______________

City: ____ State: ________Zip Code: ________________

E-mail address: ____

Patient's Employer:____________________________________Occupation:______________________

Work Telephone #: ____________________   Mobile Telephone number: ____________________

Name of Spouse: ____

What type of surgery / procedure do you want to discuss with the Doctor today?

____

Are you or have you been on a Skin Care Program? Yes___ No___ What kind?________________

When were you considering having surgery? ____Unsure _____ASAP Other: ___________

How did you select our office?

_______Friend or previous patient of Dr. Buckspan's – Name: ________________________________

_______Physician referral – Name:____

_______Internet - What sites did you visit? ____

_______Newspaper - Which publication? ____

_______Magazine - Which publication? ____

_______Yellow Pages - Which one? ____

_______ Other - Please list: ____

****

We respect your privacy. Please read and indicate your instructions to your preference of how we may contact you to continue to insure your privacy:

In the future we may contact you to remind you of any appointments, treatment options or other health services that may be of interest to you.

May we contact you at: Home? **Y / N** TEL: _____-_____ -________ OK to leave voice mail? **Y / N**

Work? **Y / N** TEL: _____-_____ -________ OK to leave voice mail? **Y / N**

Cell? **Y / N** TEL: _____-_____ -________ OK to leave voice mail? **Y / N**

Comments: ____

Can a message be left with our company name and what the call is in reference to? **Y / N**

____ ___________________________

Patient Signature Date

Randy J. Buckspan, MD, FACS

Health Questionnaire

Name:____Date:______________________

Birth Date:______________ Age:_____ Family Doctor:__________________________________

List all Drugs you are currently taking:____
____

List any Herbs and Vitamins:____

List Topical (skin) Medication:____

Have you taken aspirin/Advil/NSAIDs in the last two weeks? Yes [ ] No [ ]
Have you taken Accutane? Yes [ ] No [ ] When________
Are you taking diet pills? Yes [ ] No [ ]

Do you smoke? Yes [ ] No [ ] How much__________
Are you breast feeding? Yes [ ] No [ ]
Are you pregnant or trying? Yes [ ] No [ ]

ALLERGIES

	Yes	No	Effect		Yes	No	Effect
Penicillin……….	[ ]	[ ]	__________________________	Tape…..	[ ]	[ ]	__________________________
Other Medicine..	[ ]	[ ]	__________________________	Pollen…	[ ]	[ ]	__________________________
Jewelry/metal….	[ ]	[ ]	__________________________	Food…..	[ ]	[ ]	__________________________
Iodine…………..…	[ ]	[ ]	__________________________	Cosmetics.	[ ]	[ ]	__________________________
Shell Food……...	[ ]	[ ]	__________________________	Medication Sensitivity________________________			

List all Medication Allergies and effects:____
____

List all hospitalizations, operations (include plastic surgery), and serious injuries:

Year	Hospitalization-Operation-Injury	Hospital/Location
___________________	____	____
___________________	____	____
___________________	____	____
___________________	____	____

ILLNESS & MEDICAL PROBLEMS

	Yes	No		Yes	No		Yes	No
Dizzy Spells……	[ ]	[ ]	Low Blood Pressure..	[ ]	[ ]	Arthritis……….	[ ]	[ ]
Glaucoma……..	[ ]	[ ]	Bleed Easily……	[ ]	[ ]	Diabetes……….	[ ]	[ ]
Eye Problems…..	[ ]	[ ]	Bruise Easily…..	[ ]	[ ]	Trouble w/anesthesia	[ ]	[ ]
Ear Trouble……	[ ]	[ ]	Blood Clots…….	[ ]	[ ]	Paralysis……….	[ ]	[ ]
Sinus Trouble….	[ ]	[ ]	Anemia………….	[ ]	[ ]	Cancer…………	[ ]	[ ]
Hearing Loss…..	[ ]	[ ]	Pacemaker……....	[ ]	[ ]	Year and type Cancer_______		
Nose Bleed……..	[ ]	[ ]	Heart Attack…..	[ ]	[ ]	__________________________		
Stuffy Nose…....	[ ]	[ ]	Heart Murmur….	[ ]	[ ]	__________________________		
Back Pain………..	[ ]	[ ]	Ankle Swelling..	[ ]	[ ]	WOMEN ONLY		
Asthma…………	[ ]	[ ]	Heart Problem…	[ ]	[ ]	Tender Breasts…	[ ]	[ ]
Bronchitis…….	[ ]	[ ]	Varicose Veins..	[ ]	[ ]	Nipple Discharge	[ ]	[ ]
Emphysema……	[ ]	[ ]	Stomach Ulcer…	[ ]	[ ]	Breast Lumps….	[ ]	[ ]
Pneumonia…….	[ ]	[ ]	Colitis………….	[ ]	[ ]	Fibrocystic Disease…	[ ]	[ ]
Tuberculosis……	[ ]	[ ]	Bowel Problems.	[ ]	[ ]	Prior Mammogram…	[ ]	[ ]
Lung Disease…..	[ ]	[ ]	HIV/AIDS……...	[ ]	[ ]	Year______________		
Metal implants…	[ ]	[ ]	Hepatitis……….	[ ]	[ ]	Menstrual Problem.	[ ]	[ ]
Mononucleosis…	[ ]	[ ]	Gall Bladder……	[ ]	[ ]	Age 1st Pregnancy_________		
Headaches……..	[ ]	[ ]	Stroke………….	[ ]	[ ]	Age of Children__________		
Hypertension…..	[ ]	[ ]	Seizures……….	[ ]	[ ]	Breast Fed?…….	[ ]	[ ]

FAMILY HISTORY

	Yes	No		Yes	No		Yes	No
Tuberculosis…..	[ ]	[ ]	Diabetes……….	[ ]	[ ]	Breast Cancer……...	[ ]	[ ]
Asthma………..	[ ]	[ ]	Rheumatoid Arthritis.	[ ]	[ ]	Bleeding Tendency…	[ ]	[ ]
Glaucoma……….	[ ]	[ ]	Heart Disease….	[ ]	[ ]	Blood Disorder..	[ ]	[ ]
Cancer…………	[ ]	[ ]	High Blood Pressure.	[ ]	[ ]	Trouble w/anesthesia.	[ ]	[ ]

Relation and Type of Cancer____

Signature____