BITNER
FACIAL PLASTIC SURGERY

Cosmetic Consultation Questionnaire

Name _____ DOB _____ Today's Date _____

Whom may we thank for referring you? _____

Please identify any specific areas of interest:

☐ Face lift	☐ Brow / Forehead lift	☐ Nose	☐ Eyelids
☐ Chin	☐ Lips	☐ Neck	☐ Protruding Ears
☐ Liposuction Face/Neck	☐ Scar Revision	☐ Laser / Chemical Peel	☐ Fat Grafting
☐ Botox / Dysport	☐ Facial Filler	☐ Skin Care Products	☐ Other: _____

What specifically would you like corrected? _____
When did you begin to consider surgical correction? _____

☐ Yes ☐ No Have you had a cosmetic consultation in the past?
If yes, with whom? _____
☐ Yes ☐ No Have you discussed this surgery with your family?
☐ Yes ☐ No Is your family supportive of your decision to have elective cosmetic surgery?
☐ Yes ☐ No Are your family/friends willing to help you during your surgical recovery?
☐ Yes ☐ No Has anyone in your family or a close friend had elective cosmetic surgery?
If yes, what was done and by whom? _____

LIST ALL COSMETIC SURGICAL PROCEDURES YOU HAVE HAD

Procedure	Year	Physician/Surgeon

☐ Yes ☐ No Did you experience any complications following surgery?
If yes, explain: _____
☐ Yes ☐ No Did you have a normal recovery?
If no, explain: _____
☐ Yes ☐ No Were you and/or are you satisfied with the result?
If no, explain: _____

TANNER CLINIC

☐ Yes ☐ No Is having surgery your idea? (*If no, please explain*) _____

☐ Yes ☐ No Have you received local anesthesia (Novocaine/Xylocain) by a dentist or doctor?

☐ Yes ☐ No Have you had a "reaction" to any anesthesia? *Explain* _____

☐ Yes ☐ No Are you taking or have you taken Acutane? When? _____

☐ Yes ☐ No Are you using Retin A?

☐ Yes ☐ No Have you taken or are you using prescription skin preparations? (*If yes, please list)* _____

_____

☐ Yes ☐ No I understand that results of my surgical treatment are dependent upon full and complete disclosure of all medical and surgical information pertaining to me; and, that omission of issues relating to my health, past surgical history, current medications and allergies, or any other pertinent information may directly affect my personal safety and/or surgical result.

The information you have provided is essential to a comprehensive evaluation.

Patient signature _____ Date _____

Physician signature _____ Date _____