The Beverly Hills Institute of Aesthetic & Reconstructive Surgery
A Medical Group

COSMETIC SURGERY EVALUATION QUESTIONNAIRE

(please print all answers)

NAME: _____ AGE: _____
(first) (middle initial) (last)

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EDUCATION: _____ years Elementary _____ years High School _____ years College

OCCUPATION: _____ HOW LONG?: _____

Please circle below the types of surgery you are considering:

NOSE CHEEKS CHIN LIPS EYELIDS FACE
NECK EARS FACE PEEL SCARS HAIR
LIPOSUCTION OTHER: _____

What specific features do you dislike?

_____
_____

How long have you been thinking about having surgery?

_____

What caused you to begin thinking about having it?

_____
_____
_____

Have you read articles in newspapers, magazines or books about cosmetic surgery? Yes No

Do you understand that the object of any cosmetic operation is improvement in appearance, not perfection? Yes No

Has anyone in your family or a friend had cosmetic surgery? Yes No

If they did, what was done?

_____
_____

Did you discuss the operation with them? Yes No

Why did you wait until now to come in for correction?

_____
_____

How did you happen to select us for consultation?

_____
_____
_____

Have you consulted any other surgeon? Yes No

If you have, why didn't you have him do the work?

_____
_____
_____

Is having surgery your idea or is someone else urging you to have it?

_____

Do you feel guilty or embarrassed about wanting the operation? Yes No

If you have the operation, who do you think will be happiest with the results?

_____

Check below the reasons why you want the operation:

- ☐ To improve my appearance
- ☐ Am self-conscious about my appearance
- ☐ Have an inferiority complex about my appearance
- ☐ It makes me look ugly
- ☐ People tease me or make derogatory remarks
- ☐ To improve function
- ☐ So I can use make up better
- ☐ So I can use different hairstyles
- ☐ To help get or keep a job
- ☐ To look better for my age
- ☐ To please or impress others
- ☐ To help solve personal problems I have
- ☐ I am depressed because of my looks
- ☐ To help me solve certain social problems I have
- ☐ Because of a family resemblance I dislike
- ☐ I get few compliments about my looks
- ☐ To improve my relations with the opposite sex
- ☐ My looks prevent achievement of certain goals
- ☐ Dissatisfaction with previous surgery
- ☐ I look dissipated or tired
- ☐ I feel young; I want to look younger
- ☐ To look less masculine
- ☐ Others: _____

Check below what you expect the operation to do for you:
(check all that apply)

- ☐ Improve my appearance
- ☐ Make me more poised
- ☐ Improve my self-confidence
- ☐ No miracles
- ☐ Improve function
- ☐ Give me a psychological lift
- ☐ Help my career
- ☐ Make me less self-conscious
- ☐ Allow me to make up better
- ☐ Allow me to use different hairstyles
- ☐ Relieve my depressed feeling
- ☐ Please a relative or friend
- ☐ Solve personal problems
- ☐ Give perfection to my looks
- ☐ Make other things better in my life
- ☐ To make me beautiful
- ☐ To solve my social problems
- ☐ To look better for my age
- ☐ To improve my relationship with the opposite sex
- ☐ To cause other people to react better to me
- ☐ To help achieve goals I have set for myself
- ☐ Make me look less tired or dissipated
- ☐ Make me look more feminine
- ☐ Others: _____

_____

Do you have any preconceived idea of how you would like your nose, face, etc., to look? Yes No

If yes, how?

_____

_____

Do you realize that every operation is followed by a period of healing before the tissues return to normal and the final result is apparent? Yes No

List below any previous cosmetic operations you have had:

_____

_____

_____

Were you satisfied with the results? Yes No

Were you satisfied with the doctor(s)? Yes No

If not, why not?

_____

_____

_____

Are you presently single, married, separated, divorced or widowed?

_____

When were you married, separated, divorced or widowed?

_____

Do you live alone or with someone else (family, friends)?

_____

Have you spoken to them of your desire for surgery? Yes No

If no, do you mind if they know? Yes No

If yes, what was their attitude?

_____

_____

_____

Do you mind what they think? Yes No

Have you spoken to any of your friends about having surgery? Yes No

If no, do you mind if they know? Yes No

If yes, what was their attitude?

_____

_____

Have you recently experienced any significant disappointment, sorrow or loss of self-esteem? Yes No

Any emotional crisis at home, work or in your relationship with another person or group? Yes No

Do you:

drink more than 6 cups of coffee or tea daily?	Yes No
smoke more than a pack of cigarettes a day?	Yes No
take more than 2 alcoholic drinks every day?	Yes No
use marijuana regularly?	Yes No
use cocaine, speed, LSD, or heroin?	Yes No
have any hobbies?	Yes No
spend much time socializing with friends, your family group, etc.?	Yes No
tend to wrap yourself up in your work (school, etc.) to the almost total exclusion of other aspects of life?	Yes No
find that you are unhappy most of the time?	Yes No
feel lonely a great deal of the time?	Yes No

Medical Evaluation

How is your general health?

_____

_____

Are you under the care of a doctor for anything at the present time? Yes No

If yes, for what?

_____

_____

If no, should you be, but have been putting off consulting one? Yes No

When was your last physical examination?

_____

Was everything O.K.? Yes No

Do you seem to be ill more frequently than other people you know? Yes No

Are you having any trouble with your teeth or gums? Yes No

Do you wear partial or complete dentures? Yes No

Do you wear eye glasses or contacts or feel you need them? Yes No

Do you have any other eye complaints? Yes No

Do you have any chronic nose or sinus complaints? Yes No

Do you have frequent headaches? Yes No

Do you have asthma or any chronic lung or bronchial condition? Yes No

Do you experience recurrent chest pains? Yes No

Have you ever been told you have any trouble with your heart? Yes No

Do you have any abdominal problems? (stomach, intestinal, gall bladder, liver, hernia, etc.) Yes No

Any trouble with your kidneys, bladder or reproductive system? Yes No

Any bone, joint or muscular trouble? Yes No

Do you have any chronic skin condition? Yes No

Do you have any of the following: diabetes, epilepsy or high blood pressure? Yes No

Have you ever had a nervous breakdown? Yes No

Have you ever been under the care of a psychiatrist or psychologist? Yes No

Have you ever been dissatisfied with the treatment you received from a doctor or dentist? Yes No

Have you had any marked loss or gain of weight lately? Yes No

Are you on a special diet at the present time? Yes No

Do you bruise easier than most other people? Yes No

Do bruises seem to take longer to clear up for you than for most people you know? Yes No

Do your cuts bleed longer than those other people have? Yes No

Do the blood vessels in your skin sometimes break without apparent cause? Yes No

Have you ever had any bleeding episode that required the attention of a doctor? Yes No

(FOR WOMEN) Do your periods usually last longer than 4 or 5 days? Yes No

Have you ever had any of the following:

- Appendectomy? Yes No
- Breast surgery? Yes No
- Caesarean section? Yes No
- Childbirth? Yes No
- D & C? Yes No
- Extraction of teeth? Yes No
- Eye surgery? Yes No
- Heart surgery? Yes No
- Hemorrhoidectomy? Yes No
- Hernia repair? Yes No
- Hysterectomy? Yes No
- Kidney surgery? Yes No
- Lung surgery? Yes No
- Nose surgery? Yes No
- Skin surgery? Yes No
- Tonsils and adenoids? Yes No
- Tumor surgery? Yes No
- Others? _____

_____

If you have been operated on previously, did you have any unusual bleeding or poor scarring following surgery or following any injury or vaccination? Yes No

Did you have a normal recovery following previous surgery? Yes No

Do you understand that anyone undergoing any operation, even a cosmetic one, must assume certain risks? Yes No

Do you understand that no surgeon can ***guarantee*** good results in any operation he performs? Yes No

Were you satisfied with the results of the previous surgery you had? Yes No

Have you ever had excessive bleeding more than once during your life? Yes No

Have you ever had hemorrhage following minor surgery? Yes No

Have you suffered with recurrent nosebleeds? Yes No

As far as you know, have you ever had an allergic reaction to any of the following drugs or materials:

- Adhesive tape? Yes No
- Adrenaline? Yes No
- Antibiotics? Yes No
- Antihistamines? Yes No
- Atropine? Yes No
- Codeine? Yes No
- Compazine? Yes No
- Cortisone? Yes No
- Darvon? Yes No
- Demerol? Yes No
- Dilaudid? Yes No
- Emprin? Yes No
- Iodine preparations? Yes No
- Local anesthetics (Novocaine, Xylocaine, Cocaine, etc.)? Yes No
- Morphine? Yes No
- Nembutal? Yes No
- Neomycin? Yes No
- Seconal? Yes No
- Scopolamine (twilight sleep)? Yes No

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(continued from page 3)

Suture material?	Yes	No
Valium?	Yes	No
Vistaril?	Yes	No

Others? _____

_____

_____

Are you taking any of the following frequently or regularly:

Allergy shots?	Yes	No
Antibiotics?	Yes	No
Antidepressants?	Yes	No
Antihistamines?	Yes	No
Arthritis medicine?	Yes	No
Aspirin?	Yes	No
Barbiturates (sleeping pills)?	Yes	No
Birth control pills?	Yes	No
Blood thinners?	Yes	No
Blood vessel dilators?	Yes	No
Cortisone?	Yes	No
Diabetes medicine?	Yes	No
Diet pills?	Yes	No
Diuretics (fluid pills)?	Yes	No
Eye medicine?	Yes	No
Headache remedies?	Yes	No
Heart medicine?	Yes	No
Hormones?	Yes	No
Iron?	Yes	No
Laxatives?	Yes	No
Nose drops?	Yes	No
Pain relievers?	Yes	No
Sleeping pills?	Yes	No
Stomach medicine?	Yes	No
Thyroid medicine?	Yes	No
Tranquilizers?	Yes	No
Vitamins?	Yes	No

Others? _____

_____

_____

Is there a history of any of the following conditions in your family:

Alcoholism?	Yes	No
Allergies?	Yes	No
Bleeding tendencies?	Yes	No
Cancer?	Yes	No
Congenital defects?	Yes	No
Eccentricities?	Yes	No
Epilepsy?	Yes	No
Family estrangements?	Yes	No
Heart attacks?	Yes	No
High blood pressure?	Yes	No
Nervous breakdowns?	Yes	No
Stomach trouble?	Yes	No
Strokes?	Yes	No
Suicides?	Yes	No

List below any other facts of a medical or other nature which you feel you should make known to the Doctor before you undergo any type surgery:

_____

_____

_____

_____

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_____

DATE THIS FORM COMPLETED: _____

SIGNATURE: _____

* * * * * * * * *

List below any questions you would like to have specifically answered during your consultation:

_____

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