



PATIENT DEMOGRAPHICS

TODAY'S DATE _____

PATIENT NAME _____

BIRTHDATE _____ AGE _____ SEX ____ M ____ F

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME#(____) _____ CELL#(____) _____

May Shu Cosmetic Surgery leave a message on your... Home Phone __y __n Cell __y __n

EMERGENCY CONTACT _____

EMERGENCY CONTACT'S PHONE # _____ RELATIONSHIP TO YOU? _____

WHERE DID YOU FIND US? _____

**E-MAIL _____ REFERRED BY _____

****Don't worry, if you give us your email address we will only send you emails related to our office and your treatment.**

Have you ever had any cosmetic procedures? _____

- Breast Augmentation
- Breast Implants
- Breast Lift
- Breast reduction
- Brow Lift
- Butt Lift
- Eyelid Rejuvenation
- Facelift
- Fat Transfer
- Injectables
- Hi Def Liposculpture
- Labia Rejuvenation
- Liposuction
- Laser Skin Care
- Neck Lift
- Stem Cell Fat Transfer
- Tummy Tuck
- Upper arm lift
- Vaginal Rejuvenation



Name _____

Purpose of this visit _____

MEDICAL HISTORY: _____

MEDICATIONS: List all medications, dosages and times taken per day.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you take aspirin? ___Yes ___No

How much? _____

ALLERGIES: Medications/Foods

What was your reaction?

_____	_____
_____	_____
_____	_____
_____	_____

SURGICAL/HOSPITALIZATION HISTORY:

Date of surgery or hospitalization

_____	_____
_____	_____
_____	_____

FAMILY MEDICAL HISTORY:

RELATIONSHIP	Living	Deceased	Age	Diseases
Father	___	___	___	_____
Mother	___	___	___	_____
Brother(s)	___	___	___	_____
Sisters(s)	___	___	___	_____
Son(s)	___	___	___	_____
Daughter(s)	___	___	___	_____

SOCIAL HISTORY:

Occupation _____

Cigarettes or tobacco	___Yes ___No	How much/how often?	_____
Alcohol	___Yes ___No	How much/how often?	_____
Drugs	___Yes ___No	How much/how often?	_____

Signature of Patient or Guardian

Date



Name _____

NOTICE OF PRIVACY POLICY

Patient Name (Print): _____ Date _____

I _____, have reviewed the One Stop Medical Center Privacy Policy. I agree with all the terms of this policy.

I _____, have reviewed and request a copy of the One Stop Medical Center Privacy Policy. I agree with all the terms of this policy.