

Patient Name				Date
LAST	FIR	ST	MIDDLE	
Address	City		State	Zip
E-Mail Address		_ Date of Birth _		_ Age
Home Phone ()	Cell Phone (	)	Work (_	)
Sex Marital Status		Family Doct	or	
Social Security Number				
Whom may we thank for referring you	nś			
Reason for seeing Dr. McKenna today	:	,		
Have you seen other plastic surgeons	about the SAME pr	oblem which bring	s you here?	YES NO
Person to contact in case of emergene	cy:			
Name		Home	phone	
Address				97 W 1885
City	State Z	ip	_ Work Phone	
^^^^^		^^^^^	^^^^^	^^^^^
Height Pres	ent Weight			
Do you smoke? YES NO If y	es, how much?		·	
Are you Latex sensitive? YES	NO If yes, please	explain reaction _	<u> </u>	
Do you have Allergies - I.E. pills, drug	gs, medicine, paper	tape, etc. YES	NO	
If yes, please explain:				
Please list ALL medications you are n (water pills), blood pressure or heart i blood thinners, aspirin, bufferin, etc.)	ow taking (includin nedications, tranqu	g birth control pills ilizers, hormones,	s, herbal suppl steroid medica	ements, diuretics ations, cortisone,
	"	10 (20 th) 2 20 10 10 10 10 10 10 10 10 10 10 10 10 10		
Have you ever had a problem with G	ENERAL anesthetic	? (being put to slee	p) YES	NO
If yes, explain				
Have you ever had a problem with LO	OCAL anesthetic? (e	xample: novocain	e, etc.) YE	s no
If yes, explain				

Dr. McKenna performs all types of Facial and Body Cosmetic Surgery. **Breast Augment** Eyelid Enhancement Liposuction Breast Lift **Facelift** Nose improvement Chemical Peel Forehead lift Tummy Tuck Botox, Fillers and others If you wish information or a brochure please ask our staff or Dr. McKenna. DO YOU HAVE OR EVER HAD: High blood pressure YES NO Nasal problems YES NO Heart disease YES NO Blood transfusion YES NO Lung disease YES NO Blood clots/Excessive bleeding YES NO Kidney disease YES NO Hepatitis and/or liver disease YES NO Diabetes YES NO HIV YES NO Stroke or Seizure YES NO Depression/other psychiatric illness YES NO Heavy scars YES NO Frequent infections or boils YES NO Eye problems YES NO **FEMALES ONLY** Breast Patients - Bra Size \_\_\_\_\_ Are you pregnant now? YES NO Are you nursing now? YES NO Do you have a history of breast cancer or other breast diseases? Date of most recent mammogram? \_\_\_\_\_ Abnormal results? YES NO If yes, explain \_\_\_\_\_ Do you drink alcohol YES NO If yes, how much: \_\_\_\_\_ Please List Previous Surgeries Operation Year Complications, if any Patient Photographic Release I understand and accept that I may be recognized from my likeness or case history. Nevertheless, I authorize Peter J. McKenna, M.D. to use my photographs, videotapes, and case information in educational and scientific settings including lectures and multimedia presentations for an audience of medical professionals, at which members of the press may be present and medical, surgical and scientific journal articles. I authorize the use of photographs, videotapes and case information in the following commercial/educational settings; my surgeon's office patient educational material; my surgeon's file of pre and postoperative patient photographs available to prospective patients for viewing in the office; newspaper and magazine articles in which my surgeon participates; television programs in which my surgeon participates; my surgeon's personal web site or web page; and lectures and multimedia presentations given by my surgeon for general public.

Date: Signature: