

# RENAISSANCE

## PLASTIC SURGERY, P.C.

### QUESTIONNAIRE

Are you being seen today as a result of an accident?  yes  no if yes: \_\_\_\_\_ date

Please explain: \_\_\_\_\_

If you were injured on the job, what is the name of the Workers' Comp Insurance? \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

Please check the areas you would like to discuss today:

- |  |  |
|--|--|
| <input type="checkbox"/> Nose                | <input type="checkbox"/> Laser Hair Removal (Spa Service)      |
| <input type="checkbox"/> Face Lift           | <input type="checkbox"/> Laser Skin Rejuvenation (Spa Service) |
| <input type="checkbox"/> Eyelids             | <input type="checkbox"/> Laser Wrinkle Reduction (Spa Service) |
| <input type="checkbox"/> Ears                | <input type="checkbox"/> Skin Care (Spa Service)               |
| <input type="checkbox"/> Chin                | <input type="checkbox"/> Microdermabrasion (Spa Service)       |
| <input type="checkbox"/> Moles/Cysts         |  |
| <input type="checkbox"/> Liposuction         |  |
| <input type="checkbox"/> Scar Revision       |  |
| <input type="checkbox"/> Brow/Forehead Lift  |  |
| <input type="checkbox"/> Chemical Peel/Laser |  |
| <input type="checkbox"/> Dermabrasion        |  |
| <input type="checkbox"/> Abdominoplasty      |  |
| <input type="checkbox"/> Breast Augmentation |  |
| <input type="checkbox"/> Breast Reduction    |  |

When did you begin to consider surgical corrections? \_\_\_\_\_

Have you consulted another physician about this?  yes  no

Have you discussed this surgery with your family?  yes  no

Are they agreeable?  yes  no

Have you had cosmetic or reconstructive surgery?  yes  no

Were there complications?  yes  no

Did you have a normal recovery?  yes  no

Were you satisfied with the results?  yes  no