Cosmetic Surgery Patient Intake Form

Personal Information

First Name

Last Name

Date of Birth

Gender

Address

Phone

Email

Emergency Contact Name

Emergency Contact Phone

Relationship to Patient

Medical History

Primary Physician

Allergies

Current Medications

Past Illnesses & Surgeries

Family Medical History

Lifestyle Information

Do you smoke?

Do you drink alcohol?

Physical Activity Level

Surgery Information

Procedure Interested In

Reason for Surgery

Patient Expectations / Desired Outcome

Additional Comments