Dana Goldberg M.D.
Plastic & Reconstructive Surgery

Name: _____ Date: _____

What concerns do you have about your appearance and how are you looking to address in those concerns?

_____

Date of Birth: _____ Age: _____ Social Security Number: _____

Marital status: S M W D P Minor

Phone: _____ E-Mail: _____ Preferred Method of Contact: Phone/ Email

Registered Address: _____

City: _____ State: _____ Zip Code: _____

Height: _____ Weight: _____ Recent Weight: Gain/Loss +/- Lbs. :_____

Emergency Contact: _____

Phone: _____ E-Mail: _____

Social History

Occupation: _____

Do you Smoke or VAPE? Yes No # of cigarettes per day: _____

Have you smoked in the past? Yes No # of Years: _____Quit Date: _____

Marijuana Use? Yes No Circle: THC/ Smoking/ Edibles/ Vape/ Drops

How often do you exercise? _____ Type: _____

How much caffeine do you consume daily? _____ Daily alcohol consumption amount: _____

Medical History

Primary Physician: _____ Do you have a specialist? Yes / No Specialty: _____ Last seen: _____

Have you ever been hospitalized? Yes/ No If so, when and why?: _____

Please circle if you have been or are being treated for any of the following:

Anxiety / Depression	Diabetes (I, II, Pre)	High Blood Pressure	Stroke	Asthma/Bronchitis /breathing problems	Heart Disease	Herpes: Cold Sore/ Genital	Anemia
Auto-Immune Disease: _____	Radiation Treatment	Breast Cancer	Cancer: _____	Arthritis Chronic Back/ Neck Problems	Liver Disease	GERD/ Ulcers /stomach disorders	Blood Clotting Disorder
Hyperthyroidism Or Hypothyroidism	Problems with Anesthesia	History of Blood Clots	Hepatitis	History of Blood Transfusion	COPD	Sleep Apnea or Snoring	HIV/AIDS

Covid History:

Have you had Covid-19 in the past? Yes No If so, when: _____

Have you received the Covid-19 Vaccine? Yes No If so, when: _____

List any previous surgeries & cosmetic procedures with approximate dates:

Date	Surgery	Complications with Anesthesia	
		Yes	No
		Yes	No
		Yes	No
		Yes	No
		Yes	No

Please list all allergies and reactions:

Allergy	Reaction

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Please list any prescription medications along with dosage & frequency:

Medication	Dosage	Frequency

Please list any herbal supplements or over the counter medications along with dosage & frequency:

Supplement	Dosage	Frequency

Females Only

Date of last menstrual cycle: _____

Are you pregnant or possibly pregnant? Yes No

# of Children: _____ # of Pregnancies: _____

Have you had a mammogram? Yes No

Do you have a family history of breast cancer? Yes No

Do you plan on having more children: Yes No

Have you had a spontaneous miscarriage? Yes No

If Yes when? Location completed:

If so, which family member: _____

If you are interested in breast surgery, please list current cup size: _____ Desired cup size: _____

Authorization/ Release of Medical Photographs

_____**I understand photographs are mandatory for surgical and procedure planning and follow up**. Medical photographs may be taken before, during, or after a surgical procedure or treatment. These photographs are stored in a HIPAA-compliant database that is accessible to you. Even if I decline to have my photos released for any reason, I understand that pre-operative, intra-operative, and post-operative photographs will be taken by Dana Goldberg, M.D., and/or her associates or licensees to plan for my procedure and evaluate results.

Consent for release of photographs: I hereby authorize Dana Goldberg, M.D. and/or her associates or licensees to use pre-operative, intra-operative, and postoperative photographs for the purpose of educating: (Initial Below)

_____Other medical professionals.

_____In office use for the patients having the same procedure.

_____Posting on the World Wide Web to educate other prospective patients

_____For unrestricted marketing purposes in exchange for compensation. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images.

Privacy Policy: I have reviewed a copy of Dana Goldberg, M.D.'s Notice of Privacy Practices. (If you desire a printed copy of the notice, please notify the receptionist.)

Financial Policy

All returned checks are subject to an additional fee of $35.00 per check. There is a $50.00 charge for filling out extended work absences (short or long-term disability), Family and Medical Leave Act (FMLA). Once services are rendered or products sold, there are no refunds. Surgery and non-surgical procedures come with no warranty (guaranteed or implied) of any certain result. Perceived lack of improvement in one's condition does not translate into any type of refund.

Signature: _____ **Date:** _____

Is this your first consultation regarding the procedure(s) we will be discussing today? Yes No _____

Have you previously researched any of the various procedures we offer? Yes No _____

If so, which procedures: _____

Are you interested in financing any portion of your procedure(s)? Yes No _____

Are there any events or dates you would be planning your procedure around? Yes No _____

How did you hear about us? _____