

PRE SURGICAL ASSESSMENT

Have you had previous Cosmetic procedures?

YES

NO

IF YES, PLEASE LIST:

Have you had any other surgery?

YES

NO

IF YES, PLEASE LIST:

Did any complications such as bleeding or infection occur? YES NO

IF YES, PLEASE LIST:

Have you had any serious illness? YES NO

IF YES, PLEASE LIST:

Have you had a local or general anaesthetic in the past?

YES

NO

IF ANY COMPLICATIONS, PLEASE LIST:

Do you smoke? YES NO

IF YES, HOW MANY PER DAY?

Do you drink alcohol? YES NO

IF YES, HOW MANY PER DAY/WEEK?

Your health:					
Any allergies?	YES	NO	Do you have any of the following conditions:		
IF YES, PLEASE LIST :			Diabetes?	YES	NO
			Hypertension?	YES	NO
			Heart Problems?	YES	NO
			Respiratory Problems	YES	NO
Are you taking any medication at all at present?			Auto Immune Disease?	YES	NO
IF YES, PLEASE LIST :			Back Problems?	YES	NO
			Have you been treated for depression in the past?	YES	NO
Have you been tested for HIV Hep B and C	RESULTS				

What procedure are you interested in?

How long have you wanted to have this procedure?

Do you think you have realistic expectations?

YES

NO

Are you aware of the fact that our procedures are conducted with twilight sedation rather than general anaesthetic?

YES NO