



SCOTT W. MOSSER, M.D.
PLASTIC SURGERY

Name: _____ Date: _____
(First) (Middle) (Last)

Parent's Name (if patient is a minor): _____
(First) (Middle) (Last)

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Home Phone: (____) _____

Work Phone: (____) _____ Cell Phone: (____) _____

Email: _____

Emails are never shared. Would you like to receive our health & beauty E-newsletter? _____

Employed by: _____ Occupation: _____

Spouse's Name: _____ Occupation: _____

How were you referred to Dr. Mosser? Internet (specific search engine or website you used): _____

A Patient: _____ Physician: _____ Other: _____

Health Insurance Company (necessary to schedule all types of surgery) : _____

BODY AREAS (please mark areas you would like to discuss today)

Cosmetic Face Procedures:

- Brow / forehead rejuvenation
- Eyelid improvement
- Nose shape or size
- Face Lift
- Cheeks
- Lips (wrinkles or fullness)
- Chin (too large or too small)
- Neck (skin or fat excess)
- Fillers (Restylane, Radiesse or Sculptra)

Cosmetic Breast Procedures:

- Breast Augmentation
- Breast lift
- Breast Reduction

Cosmetic Body Procedures:

- Liposuction
- Tummy Tuck
- Buttock Lift / Brazilian Butt Lift
- Lower Body Lift
- Thigh Lift / Arm Lift

Reconstructive Procedures:

- Breast Reconstruction
- Mole Removal
- Scar Revision
- Other (please specify): _____

What is your greatest concern about undergoing plastic surgery? _____

What time frame are you considering? How far in the future would you ideally like to have your surgery? (circle one)

2 weeks

4-6 weeks

6 months

1 year



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CURRENT AND PAST MEDICAL HISTORY

Age: _____ Current Height: _____ Current Weight: _____ Lifetime Highest Weight: _____

Do you smoke? _____ If so, how much? _____

Have you had any serious injuries? _____

Are you allergic to any medications (please list medication and your allergic response is)? _____

Do you take aspirin regularly? _____ Other Medications (please list)? _____

Do you take nutritional or herbal supplements (please list)? _____

Have you ever had any difficulties with Anesthesia? _____

Previous Surgeries (please list with dates)? _____

Have you ever had excessive bleeding, i.e. following surgery; nosebleeds, etc.? _____

Name of your personal Physician: _____

In case of emergency call: _____ Relationship: _____ Phone number: _____

Have you ever had? (Please circle each yes or no):

Blood Disease	Yes	No	Kidney Disease	Yes	No
Cancer	Yes	No	Diabetes	Yes	No
Heart Disease	Yes	No	High Blood Pressure	Yes	No
Lung Disease	Yes	No	Epilepsy	Yes	No
Hepatitis	Yes	No	HIV Tested	Yes	No
Migraine Headaches	Yes	No	Result: _____	(Optional Answer)	

Other Ongoing Medical Issues: _____

For *Women Breast & Body* Consults: Number of pregnancies: _____ Bra Size: _____