Dr. Rodolfo Castillo Calderón

Certified Plastic Surgeon

Date:

Name: (Last) (First) (MI) ☐ Male ☐ Female
Address:
City: State: Zip code:
Home Phone: Cell Phone: Work Phone:
Date of Birth: Email Address:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Occupation: Ethnicity:
How do you know about Dr. Castillo?

EMERGENCY CONTACT INFORMATION

Name: Relationship:
City/Location: Phone Number:

REASON FOR AESTHETIC CONSULT:

☐ Breast Augmentation ☐ Breast Lift ☐ Breast Reduction ☐ Breast Reconstruction ☐ Male Breast Reduction
☐ Liposculpture ☐ Tummy Tuck ☐ Arm Lift ☐ Thigh Lift ☐ Mommy Makeover
☐ Body contouring After Massive Weight Loss ☐ Butt Lift ☐ Butt Augmentation ☐ Upper Body Lift ☐ Face Lift
☐ Neck Lift ☐ Nose Reshaping ☐ Eyelid Surgery ☐ Ear Surgery ☐ Botox/Fillers
Other:

HEALTH AND MEDICAL INFORMATION:

Age: Height: Weight:
Have you ever smoked? ☐ yes ☐ No If Yes, packs per day: Still Smoke? ☐ Yes ☐ No Date You Quit:
If you drink: drinks per ☐ day ☐ week ☐ Month How Many cups of coffee per day?

ADDITIONAL HEALTH HISTORY List dates of your most recent

Physical/Check up Normal? ☐ Yes ☐ No Heart Tracing (EKG) Normal? ☐ Yes ☐ No
Chest X-Ray Normal? ☐ Yes ☐ No Blood Work Normal? ☐ Yes ☐ No

Women Only: How Many Pregnancies have you had? How Many Children Born alive? How Many C-sections?
Is there any chance you could be pregnant? ☐ Yes ☐ No Date of most recent Breast Exam:
Are you having regular menstrual periods? ☐ Yes ☐ No Date of most recent Mammogram:
Heavy Bleeding with your periods? ☐ Yes ☐ No Birth control Method:

MEDICATIONS: Please list all the medications you are currently taking, prescription and non prescription, supplements, vitamins, diet pills and those medications you may not take every day. Please also include the dose of medication.

Medication/Dose	Medication/Dose

ALLERGIES: Please list all allergies to medications, tape, latex, iodine, etc. and the reaction you have when exposed

☐ **I have no known drug allergies**

SURGICAL HISTORY:
Please list your surgical history and/or serious accidents or injuries. Please include the approximate date.

	PROCEDURE	DATE
1		
2		
3		
4		
5		

Have you and/or any of your family members had any anesthesia complications? ☐ Yes ☐ No
If yes, please describe:

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS: please check all that apply

NEUROLOGICAL
☐ Migraines
☐ Stroke
☐ Seizures
☐ Head Injury
☐ Depression

BLOOD
☐ Anemia
☐ Bleeding Disorder
☐ Blood Clots/DVT
☐ AIDS/HIV+
☐ Nose Bleeds
☐ Prior Transfusion

PULMONARY
☐ Asthma
☐ Tuberculosis
☐ Emphysema
☐ Pulmonary Embolism

CARDIOVASCULAR
☐ Heart Disease
☐ Chest Pain
☐ High Blood Pressure
☐ Heart Attack
☐ Heart Murmur
☐ Swollen Legs/ankles
☐ Palpitations

SKIN/IMMUNE
☐ Arthritis/Joint Pain
☐ Back/Neck Pain
☐ Skin Disorder
☐ Lupus
☐ Sclerodermia
☐ Pigmentation

GENERAL
☐ Fever
☐ Weight loss/gain
☐ Night Sweats
☐ Loss of Appetite

HEAD/NECK
☐ Change in Vision
☐ Nasal Blokage
☐ Sore Throat
☐ Sinusitis
☐ Wear contacts/glasses

ENDOCRINE
☐ Heat/cold intolerance
☐ Diabetes
☐ Thyroid Problems

GASTROINTESTINAL
☐ Constipation
☐ Reflux Disease
☐ Diarrhea
☐ Hepatitis/jaundice
☐ Frequent urinary infection

ALLERGY
☐ Tape Allergy
☐ Environmental
☐ Iodine Allergy
☐ Latex Allergy

CANCER, Type: **OTHER:**