



MITESH KAPADIA, MD, PhD
OPHTHALMIC PLASTIC SURGERY

Name: _____ Today's Date: _____

Referred by: _____ (name and location)

Primary care physician: _____ (name and location)

Other physicians whom you would like to receive a report of this consultation:
_____ (name and location)

1. Briefly describe why you are here:

2. Circle below if you have any of the following medical problems:

- | | | | |
|---------------------|-------------|------------------------|-------------------|
| heart attack | stroke | artificial heart valve | skin cancer |
| cardiac stents | blood clots | irregular heartbeat | other cancer |
| high blood pressure | diabetes | thyroid disease | bleeding disorder |

3. Please list all other medical problems:

4. Circle any of the following medications you take regularly or occasionally.

- | | | | |
|----------------------|-----------------|------------------|-----------------|
| aspirin | coumadin | plavix | alleve/naprosyn |
| other blood thinners | st. john's wart | celebrex | |
| ginkgo baloba | vitamin e | motrin/ibuprofen | |

5. Please list all other medicines (prescription and non-prescription) not mentioned above. You do NOT need to list the dosages.

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. Please list medications which you are allergic to:

7. Do you currently smoke cigarettes? Yes No

If yes: _____ packs per day for _____ years.

8. Do you have problems with any of the following not already mentioned above?

- | | | |
|--|--|---|
| Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> sinuses | <input type="checkbox"/> <input type="checkbox"/> lungs/breathing | <input type="checkbox"/> <input type="checkbox"/> heart |
| <input type="checkbox"/> <input type="checkbox"/> urinary system | <input type="checkbox"/> <input type="checkbox"/> stomach/intestines | <input type="checkbox"/> <input type="checkbox"/> joints/muscles |
| <input type="checkbox"/> <input type="checkbox"/> skin | <input type="checkbox"/> <input type="checkbox"/> endocrine/glands | <input type="checkbox"/> <input type="checkbox"/> neurologic system |

If yes, explain:

9. What is your occupation?

10. Are there any medical problems that run in your family?

11. Please list any prior eyelid surgeries or other cosmetic surgeries. Specify year and surgeon if possible.

12. Circle any of the following products or treatments you have had in the past

- | | | | |
|------------------------|-----------|---------------|----------------------|
| Botox cosmetic | Restylane | Juvederm | other facial fillers |
| laser skin resurfacing | Thermage | chemical peel | Retin-A treatment |

13. Circle any of the following areas which you may be interested in improving:

- | | | |
|---------------------------------|-------------------------|-----------------------------|
| drooping eyelids | puffy eyelids | looking "tired" |
| hollowing in lower eyelids | excess eyelid skin | lines under and around eyes |
| lines between eyes (angry look) | dark circles under eyes | frown on corner of mouth |
| crease nose to corner of mouth | thin face, no cheeks | thin lips |
| lines around lips | removal of moles | |

14. Circle any of the following products/treatments you may be interested in:

- | | | |
|---------------------------|-------------------------|----------|
| Botox | Restylane | Juvederm |
| medical grade skin creams | medical grade cosmetics | |

15. Additional comments:
