ORANGE COUNTY
PLASTIC SURGERY
JOHN COMPOGINIS, MD, FACS
JURIS BUNKIS, MD, FACS

Today's Date: ____________
Name (Last, First, Middle) ____

Gender Identity: ________________________________

Age: ______ Birthdate: _______________ Height: ________ Weight: ________
Street Address ____
City, State & ZIP ____
Cell Phone ______________________ Email address _____________________________
May we text you?
- ☐ Yes
- ☐ No

May we email you?
- ☐ Yes
- ☐ No

Occupation: _______________________________ Employer: __________________________________
Pharmacy Name: ____ Phone: _______________________
Spouse/ Responsible party: ____
List the reason(s) for your visit today: ____
List any previous surgery: ____
List all medical conditions for which you are presently being treated:_____________________________
____
List all medications you are currently taking or have taken in the last 6 months: ____________________
____

Number of Children: _________

Alcohol Use:
- ☐ Yes
- ☐ No

Tobacco use:
- ☐ Yes
- ☐ No

Recreational Drug Use:
- ☐ Yes
- ☐ No

How did you hear of us?
- ☐ Google
- ☐ Groupon
- ☐ Yelp
- ☐ Our patient: ____________________________________
- ☐ Magazine: ________________________
- ☐ Other: ________________________________

Would you like to receive email announcements on special discounts, new products, or procedures?
- ☐ Yes
- ☐ No

If Yes, what email address can we send it to? ____________________________

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Authorization: I hereby authorize medical treatment of the person named above, and agree to pay all fees and charges for treatments and services rendered. I understand that medical treatment may include a review of personal, social and medical history, discussion of the reason(s) for the visit(s), and may include photographs of the area(s) being discussed and or treated before and/or after treatment. I have read and agreed to the above.

Signature: ________________________________ Date:________________________________

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): ________________________________

Relationship to Patient: ________________________________

Please note that we require a copy of your government-issued photo identification for your record.

Medical History

Cardiovascular:
- ☐ High blood pressure
- ☐ Heart attack(s)
- ☐ Pacemaker
- ☐ Coronary artery disease
- ☐ Murmur / Mitral valve prolapse
- ☐ Irregular heartbeat / palpitations
- ☐ Other: ________________

Pulmonary:
- ☐ Asthma
- ☐ Chronic cough
- ☐ Pulmonary Embolism
- ☐ Shortness of breath
- ☐ Sleep Apnea
- ☐ Other: ________________

Neuromuscular:
- ☐ Muscle weakness
- ☐ Nerve damage
- ☐ Facial paralysis / Weakness
- ☐ Headaches
- ☐ Seizure disorder / Convulsions
- ☐ Spinal / Back disorders
- ☐ Other: ________________

Psychological:
- ☐ Depression
- ☐ Anxiety
- ☐ Claustrophobia
- ☐ Receive(d) psychiatric treatment
- ☐ Drug / Alcohol dependency treatment
- ☐ Body Dysmorphia Disorder
- ☐ Psychiatric hospitalization
- ☐ Other: ________________

Ears / Nose / Throat:
- ☐ Difficulty breathing by nose
- ☐ Previous nasal injury
- ☐ Difficulty opening mouth
- ☐ History of sinus infections
- ☐ Hearing difficulty/Tinnitus
- ☐ Hoarseness
- ☐ Other: ________________

Eyes:
- ☐ Dry eye
- ☐ Blurred / Double vision
- ☐ Cornea problems
- ☐ Glaucoma
- ☐ Wears glasses or contacts
- ☐ Other: ________________

Endocrine:
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Lupus
- ☐ Other: ________________

Hepatic:
- ☐ Hepatitis (Type: ___)
- ☐ Pancreatitis
- ☐ Cholecystitis
- ☐ Other: ________________

Renal:
- ☐ Renal failure
- ☐ Dialysis
- ☐ Other: ________________

Hematology:
- ☐ Anemia - Low hemoglobin
- ☐ Blood transfusion
- ☐ Blood Clots
- ☐ Bleeding disorder
- ☐ Stroke
- ☐ Bruise Easily
- ☐ Other: ________________

Gastrointestinal:
- ☐ Colitis
- ☐ Anorexia/Bulimia
- ☐ Reflux disease
- ☐ Stomach ulcers
- ☐ Other: ________________

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Immunologic / Infectious:
- ☐ HIV / AIDS
- ☐ Sexually transmitted disease
- ☐ Staph / Strep / MRSA
- ☐ Tuberculosis (TB)
- ☐ Autoimmune disorder
- ☐ Other: ________________

Allergies:
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Other: ________________

Dermatological:
- ☐ Excessive sweating
- ☐ Cold sores / herpes
- ☐ Acne
- ☐ Rosacea
- ☐ Eczema
- ☐ Psoriasis
- ☐ Radiation to face / neck
- ☐ Scarring / Keloid formation
- ☐ Slow wound healing
- ☐ Other: ________________

Cancer:
- ☐ Basal cell cancer (Self/Family)
- ☐ Breast Cancer
- ☐ Squamous cell cancer (Self/Family)
- ☐ Location: ________________

Other than the services we have already provided for you, what additional concerns or treatments/procedures would you want to learn more about? Please check all that apply.

Non-surgical Skin Care
- ☐ Skin Care Advice
- ☐ Skin Care Products
- ☐ Skin Tightening
- ☐ Facial Injectables/ Fillers
- ☐ Lip Fillers
- ☐ Eyelashes
- ☐ Brown/Age Spots
- ☐ Freckles
- ☐ Chemical Peels
- ☐ Blotchy Skin
- ☐ Facial Redness
- ☐ Facial veins
- ☐ Brown/Age Spots
- ☐ Unwanted Hair
- ☐ Other ________________________

Face/Neck
- ☐ Facial Rejuvenation
- ☐ Drooping Eyebrows
- ☐ Drooping Eyelids
- ☐ Nose Shape or Size
- ☐ Facial or Cheek Fullness1
- ☐ Lip Fullness
- ☐ Neck Looseness
- ☐ Protruding Ears
- ☐ Weak Chin
- ☐ Mole Removal
- ☐ Other ________________________

Breast/Chest
- ☐ Breast Size or Shape
- ☐ Chest Size
- ☐ Breast Drooping
- ☐ Nose Shape or Size
- ☐ Areolar Size
- ☐ Breast Implant Exchange
- ☐ Breast Implant Removal
- ☐ Accessory Nipples
- ☐ Other ________________________

Body
- ☐ Excess skin on abdomen
- ☐ Excess fat
- ☐ Arm sagging
- ☐ Thigh Sagging
- ☐ Enlarged Labia
- ☐ Buttock Size or Shape
- ☐ Calf Size or Shape
- ☐ Bicep Size or Shape
- ☐ Other ________________________