



Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
LAST FIRST MIDDLE

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Family Doctor \_\_\_\_\_

Social Security Number \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Reason for seeing Dr. McKenna today: \_\_\_\_\_

Have you seen other plastic surgeons about the SAME problem which brings you here? YES NO

Person outside of household to notify in case of emergency:

Name \_\_\_\_\_ Home phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

Height \_\_\_\_\_ Present Weight \_\_\_\_\_

Do you smoke? YES NO If yes, how much? \_\_\_\_\_

Are you Latex sensitive? YES NO If yes, please explain reaction \_\_\_\_\_

Do you have Allergies - I.E. pills, drugs, medicine, paper tape, etc. YES NO

If yes, please explain: \_\_\_\_\_

Please list ALL medications you are now taking (including birth control pills, herbal supplements, diuretics (water pills), blood pressure or heart medications, tranquilizers, hormones, steroid medications, cortisone, blood thinners, aspirin, bufferin, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had a problem with GENERAL anesthetic? (being put to sleep) YES NO

If yes, explain \_\_\_\_\_

Have you ever had a problem with LOCAL anesthetic? (example: novocaine, etc.) YES NO

If yes, explain \_\_\_\_\_

**Dr. McKenna performs all types of Facial and Body Cosmetic Surgery.**

Breast Augment	Eyelid Enhancement	Liposuction
Breast Lift	Facelift	Nose improvement
Chemical Peel	Forehead lift	Tummy Tuck
Botox, Fillers and others		

If you wish information or a brochure please ask our staff or Dr. McKenna.

**DO YOU HAVE OR EVER HAD:**

High blood pressure	YES	NO	Nasal problems	YES	NO
Heart disease	YES	NO	Blood transfusion	YES	NO
Lung disease	YES	NO	Blood clots/Excessive bleeding	YES	NO
Kidney disease	YES	NO	Hepatitis and/or liver disease	YES	NO
Diabetes	YES	NO	HIV	YES	NO
Stroke or Seizure	YES	NO	Depression/other psychiatric illness	YES	NO
Heavy scars	YES	NO	Frequent infections or boils	YES	NO
Eye problems	YES	NO			

**FEMALES ONLY**

Breast Patients - Bra Size \_\_\_\_\_

Are you pregnant now? YES NO      Are you nursing now? YES NO

Do you have a history of breast cancer or other breast diseases? YES NO

Date of most recent mammogram? \_\_\_\_\_ Abnormal results? YES NO

If yes, explain \_\_\_\_\_

Do you drink alcohol YES NO If yes, how much: \_\_\_\_\_

Please List Previous Surgeries  
Operation

Year

Complications, if any

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**Patient Photographic Release**

I understand and accept that I may be recognized from my likeness or case history. Nevertheless, I authorize Peter J. McKenna, M.D. to use my photographs, videotapes, and case information in educational and scientific settings including lectures and multimedia presentations for an audience of medical professionals, at which members of the press may be present and medical, surgical and scientific journal articles. I authorize the use of photographs, videotapes and case information in the following commercial/educational settings; my surgeon's office patient educational material; my surgeon's file of pre and postoperative patient photographs available to prospective patients for viewing in the office; newspaper and magazine articles in which my surgeon participates; television programs in which my surgeon participates; my surgeon's personal web site or web page; and lectures and multimedia presentations given by my surgeon for general public.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_