Dr. Bert Oelbrandt
Plastic Surgeon
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ISAPS certified plastic surgeon (4281 - http://www.isaps.org/find-a-surgeon/profile/4281/)

CONSULTATION FORM Date: _____/_____/ _____

Surname: _____ First name: _____

Date of birth: _____/_____/_____ Gender: male / female / other: _____

Address: _____City: _____

Postal code: _____ Country: _____

Mobile phone number: _____

Email address: _____

Profession: _____

Married/divorced/single/widow

Procedure of interest: _____

Since how long do you consider this procedure? _____

What do you expect from this procedure? Can you explain in your own words why you would like this procedure? What are the priorities? What is your main area of concern?

_____

_____

May we contact your family doctor? YES/NO

How many hours per day are you looking in the mirror? _____ Do you avoid the mirror? YES/NO

Are there things you avoid because of how you look? YES/NO

Has your appearance often gotten in the way of doing things with friends, your family, or dating? YES/NO

Is your partner/family informed about this procedure? YES/NO Feedback: positive/negative

Have you ever been depressed or did you ever take antidepressants? YES/NO

Have you already had a consultation with another clinic or surgeon regarding this procedure? YES/NO

Signature patient:

Previous surgical/cosmetic procedures (please advise of any problems with the local/general anesthetic and list all cosmetic procedures?)

Which sport do you practice and how many times per week? _____

Smoking: YES/NO (_____ cigarettes per day/stopped since _____/_____/_____)

Do you drink alcohol? YES/NO How many glasses a week? _____

Medication (contraception pill, HRT, inhalers, nicotine patches or chewing gum, drugs, cocaine, homeopathy, vitamin C or E, Ginseng, Gingko Biloba, …):

Allergy (penicillin, Latex , other…): _____

Do you have any medical problems (heart, blood pressure, lungs, anemia, ….)? YES/NO

Do you bruise easily? YES/NO

Approximate date of your last blood check:_____

Family History for: breast cancer, blood clots, bleeding, heart disease, anything else? _____

Do you suffer from any of the following?

Heart condition, blood pressure, diabetes type I / II , anemia, sickle Cell, asthma, embolism, kidney condition, skin condition (acne, …), blood clots in legs/lungs/elsewhere, zoster, weight loss, blood loss in stools/urine, thyroid disorder, infection (sinusitis, bladder, hepatitis, HIV, herpes, cold sores, tooth, throat), weight loss, eye condition (glaucoma, dry eyes, lazy eye), brain condition (head ache, depression, epilepsy), joint/back/neck (pain, arthritis), tooth decay, pain in the chest/arms/legs, facial pain, short of breath, …

Are there any comments that you would like to add?

The limitations, complications and alternatives of the procedure will be discussed during the consultation.
For most procedures we recommend a second consultation, free of charge.