George T Matsuda, MD FACOG

AESTHETIC HISTORY AND PHYSICAL Date: _____

Patient Name: _____ **Medical Record #:** _____
Age: _____ **Date of Birth:** _____ **Last Menses (1"Day):** _____
Pregnancies: _____ **Births:** _____ **(Vaginal** _____ **Caesarean** _____**) Miscarriages:** _____ **Abortions:** _____
Address: _____
_____
Phone (Home): _____ **Allergies:** ☐**None (NKA)**
Phone (Work): _____ ☐**Yes** _____
Phone (Cell): _____ _____
Phone (Fax): _____ _____
Email: _____ _____
How did you hear about us? Referred by: _____
CHIEF COMPLAINT (Why you want to see the doctor today?)
_____
_____
_____
_____
_____
_____

INTERESTED IN AESTHETC LABIAL AND/OR VAGINAL SURGERY

_____ I want aesthetic vaginal surgery
_____ My labia are large /looser than what I want
_____ I do not like the way my labia looks
_____ My labia rug, tug, and pull on my clothing I want
_____ I am unable to were type of clothing
_____ I have had unflattering comments about my genital region
_____ I have had difficult births
_____ My vagina fells too loose inside
_____ I have decreased sensations
_____ I feel pelvic heaviness/pressure
_____ Sex is uncomfortable/unpleasant
_____ I am interested in G-Spot treatments

INTERESTED IN NON-SURGICAL THERMIVA

☐ To tighten the labia majora
☐ To tighten the vagina
☐ To treat a leaky bladder
☐ TO reduce urinary urgency and frequency
☐ To improve vulvar and vaginal moisture
☐ To improve sensitive of tissues
☐ To improve or achieve orgasms
☐ Reduce painful intercourse

INTERESRED IN AESTHETIC LASERS/IPL/RADIOFREQUENCY TREATMENTS

☐ I want Vulvar lightening
☐ I want to remove brown spots/sun damage
☐ I want Collagen/Vitamin C Facial
☐ I want Skin Tightening
☐ I want Stretch Marks/Scar Reduction
☐ I want Hair or/and Vein reduction

PAST MEDICAL HICTORY/REVIEW OF SYSTEMS: Circle all that apply, Give details

☐ **Skip this section. I am completely healthy without any conditions mentioned below.**

Are you physically active?
What type of exercise? _____

Do you now have or have you ever had: ☐ Yes ☐ No _____
Neurologic problems (seizures, headaches, weakness, paralysis)? ☐ Yes ☐ NO _____
Psychiatric problems? Depression? Mania? Bipolar? ☐ Yes ☐ NO _____
Head/Ear/Eyes/Nose/Nose/Throat Problems? ☐ Yes ☐ NO _____
Thyroid problems or glandular problems? ☐ Yes ☐ NO _____
Cardiac (heart) problems? Palpitations? Chest Path? Irregular Bea ☐ Yes ☐ NO _____

Lung problems? Asthma? Short of Breath?	☐ Yes ☐ No _____
Breast Problem? Mass? Lumpiness? Discharge? Pain?	☐ Yes ☐ No _____
Gastrointestinal (stomach) problem (gas, reflux, irritable bowel)?	☐ Yes ☐ No _____
Kidney or bladder disease? Stones? Infections? Blood in urine?	☐ Yes ☐ No _____
Liver problems such as hepatitis?	☐ Yes ☐ No _____
Hematologic problems such as bleeding or anemia?	☐ Yes ☐ No _____
Diabetes (insulin dependent/oral medication) or low sugar?	☐ Yes ☐ No _____
Musculoskeletal (bones, joints, muscies) problems?	☐ Yes ☐ No _____
Criculation problems (varicose veins, thrombosis, blood clots)?	☐ Yes ☐ No _____
Cancer or Pre-Cancerous Conditions	☐ Yes ☐ No _____
High Blood Pressure or Low Blood Pressure/Fainting Spells	☐ Yes ☐ No _____
Hernias in the abdomen?	☐ Yes ☐ No _____
Problems with anesthesia, nauses, anxiety reaction?	☐ Yes ☐ No _____
Std (HIV, Gonorrhea, Chlamydia, nausea, anxiety reaction?	☐ Yes ☐ No _____

Other Problems: _____
_____
_____

PAST SURGERIES OR PROCEDURES OR HOSPITALIZATION

☐**NONE**

Please list with date:

_____
_____
_____
_____

FAMILY HISTORY: (Write which has occurred in any blood relative and write relationship to you):

_____None significant

_____Family _____
_____

SOCIAL HISTORY:

Marital status: S M W D

Education: _____

Occupation: ☐Not Working ☐Working where Working _____
What Occupation _____

Tobacco use: ☐No ☐yes Caffeine use: ☐No ☐Yes
Alcohol use: ☐No ☐Yes Other Drugs: ☐No ☐Yes
Abuse: ☐No ☐Yes Describe _____

MEDICATIONS:

☐**NONE** ☐**SEE ATTACED LIST**

Please lost all current medications and dosages

_____
_____
_____
_____

EXAMINATION:

Constitutional: Ht_____ Wt_____ BMI_____

Temp _____ BP _____ Pulse _____ Respiration _____

	Normal	**Abnormal**
Appearance	[ ]	[ ]
NEENT	[ ]	[ ]
Heart:	[ ]	[ ]
Lungs:	[ ]	[ ]
Breast/Chest:	[ ]	[ ]
Abdomens:	[ ]	[ ]
Extremes:	[ ]	[ ]
Skin:	[ ]	[ ]
Lymph Nodes	[ ]	[ ]
Nerves	[ ]	[ ]
Pelvic	[ ]	[ ]

Other:

_____
_____
_____
_____

Drawings/Measurement:

IMPRESSION:

_____
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PLAN & RECOMMENDATIONS:

_____
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_____

DISCUSSIONS:

☐ Risks/Benefits/Options of procedure
☐ Meet With Finance/Business Office
☐ Meet with Scheduler
☐ Read Education Materials
☐ Review Website Videos and Articals
☐ Review Pre and Post Op Instructios
☐ Discuss/Schedule Pre & Post Op Photos
☐ Skin care and Sun Exposure

POLLOW UP _____Days _____Weeks _____Months _____Years/s

PATIENT SIGNATURE _____

DOCTOR SIGNTURE _____

DATE _____