

**MICHAEL F. HYNES, M.D., F.A.C.S.**  
**HYNES PLASTIC SURGERY CENTER, P.C.**  
**930 Carondelet Drive, Suite 102**  
**Kansas City, MO 64114**

**Patient** \_\_\_\_\_ **Date** \_\_\_\_\_  
Last Name First Name Middle Initial

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ CELL: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Sex:  M  F Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed

Patient's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Your reason to see the Doctor today:** \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Patient's Primary Care Physician:** \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Phone: \_\_\_\_\_

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**How did you first learn about Dr. Hynes?**

Internet  Website: \_\_\_\_\_  TV  Friend/Family \_\_\_\_\_

Magazine: \_\_\_\_\_  PhoneBook  Newspaper  Other \_\_\_\_\_

**Your E-mail Address:** (print clearly) \_\_\_\_\_

Yes  No I would like to receive **Dr. Hynes' E-mail NEWSLETTER about cosmetic surgery updates.**

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**TODAY I WANT TO TALK TO DR. HYNES ABOUT:** (please check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Breast Augmentation or Lift   | <input type="checkbox"/> BOTOX® Cosmetic                 |
| <input type="checkbox"/> Liposuction/Laser-Liposuction | <input type="checkbox"/> Injectables for facial wrinkles |
| <input type="checkbox"/> Tummy Tuck                    | <input type="checkbox"/> Skin Care Analysis              |
| <input type="checkbox"/> Eyelid Surgery                | <input type="checkbox"/> Micro dermabrasion              |
| <input type="checkbox"/> Face Lift                     | <input type="checkbox"/> Age Spots/liver spots           |
| <input type="checkbox"/> Facial Laser Resurfacing      | <input type="checkbox"/> Spider Veins (face or legs)     |
| <input type="checkbox"/> Brow Lift/Neck Lift           | <input type="checkbox"/> Laser Hair Removal              |
| <input type="checkbox"/> Skin Care Products            | <input type="checkbox"/> Skin Rejuvenation               |
| <input type="checkbox"/> Other, please specify: _____  | <input type="checkbox"/> MicroLaser Peel                 |

## PERSONAL FAMILY & SOCIAL HISTORY

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Do you have any allergies to medications or other? \_\_\_\_\_

Do you exercise? Yes No How often? \_\_\_\_\_

Type of exercise? \_\_\_\_\_

Do you smoke? Yes No Cigarettes per day: \_\_\_\_\_ Cigars? \_\_\_\_\_ Pipe? \_\_\_\_\_

Chewing tobacco? Yes No How long have you been smoking/chewing? \_\_\_\_\_

Do you drink regularly? Yes No \_\_\_\_\_ Socially \_\_\_\_\_ Heavy \_\_\_\_\_ Prior Addiction

Have you ever had a drug dependency? \_\_\_\_\_ No, Never \_\_\_\_\_ Yes, Previously \_\_\_\_\_ Prior Addiction

### Have you had any of the following?

Blood in Stool	Yes	No	Anxiety	Yes	No
Recent weight loss or gain	Yes	No	Ulcers	Yes	No
Teeth or gum problems	Yes	No	Gas	Yes	No
Eye Pain, redness	Yes	No	Jaundice	Yes	No
Hepatitis	Yes	No	Stomach pain	Yes	No
Vision problems	Yes	No	Kidney Disease	Yes	No
Bladder Infections	Yes	No	Hernia	Yes	No
Blood in urine	Yes	No	Stomach or duodenal ulcers	Yes	No
Any nose bleeds	Yes	No	Burning/itching w/urination	Yes	No
High blood pressure	Yes	No	Frequent urination	Yes	No
Heart attack or angina	Yes	No	Prostate problems	Yes	No
Chest pain or pressure	Yes	No	Diabetes	Yes	No
Heart palpitations	Yes	No	Thyroid Disease	Yes	No
Shortness of breath	Yes	No	Problems w/blood sugar	Yes	No
Stroke or mini-strokes	Yes	No	Cancer	Yes	No
Tremors or numbness	Yes	No	Coughing up blood	Yes	No
Loss of Consciousness	Yes	No	Hay Fever	Yes	No
Migraine Headaches	Yes	No	Wheezing	Yes	No
Emphysema	Yes	No	Gout	Yes	No
Asthma	Yes	No	Arthritis	Yes	No
Easy bruising or bleeding	Yes	No	Leg cramps or swelling	Yes	No
Swollen glands	Yes	No	Swollen joints	Yes	No
Concerning rashes	Yes	No	Depression	Yes	No
Changes in Moles	Yes	No	Panic	Yes	No
			HIV/AIDS	Yes	No

**List all Current Medications:**

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By signing below, I attest that the information I have provided on this form is complete and true to the best of my knowledge.

**Patient's**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_