Directions to *Houston Location*
Houston Cosmetic Surgery Center
713-868-3223 * 1961 W TC Jester, Houston TX 77008
(Located on West TC Jester approximately 1 mile South of 610 North Loop West just before Ella Blvd)

From I10 East (Baytown area) - Travel west on I10, exit 610 Loop North. Stay on 610 traveling North then West. Exit East and West TC Jester. Turn left at the 2nd traffic light (West TC Jester). Travel under 610 over pass about one mile through a residential area, the clinic will be on the right.

From I10 West (Katy area) - Travel east on I10, exit 610 North Loop. Stay on 610 bearing right at the 290 split. Exit West TC Jester the first exit on the North Loop. Turn right at the traffic light (West TC Jester). Travel about one mile through a residential area, the clinic will be on the right.

From I45 North (Greens Point area) -
Travel south on I45, exit 610 North Loop West. Travel West on 610. Exit East and West TC Jester. Turn left at the 2nd traffic light (West TC Jester). Travel under 610 over pass about one mile through a residential area, the clinic will be on the right.

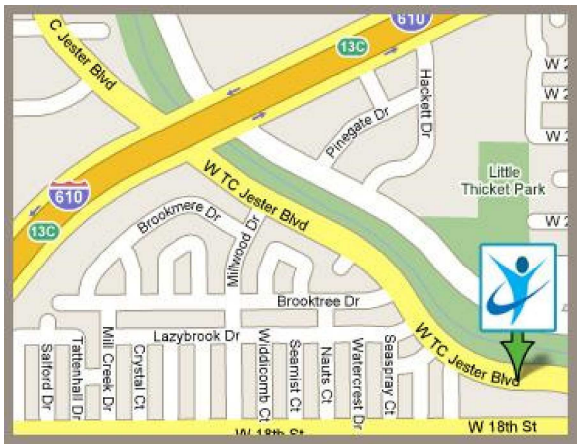
From I45 South (Galveston area) - From I45 South (Galveston area), travel north on I45 past 610 South Loop towards Downtown. Exit 610 North Loop West past Downtown. Travel West on 610. Exit East and West TC Jester. Turn left at the 2nd traffic light (West TC Jester). Travel under 610 over pass about one mile through a residential area, the clinic will be on the right.

From Hwy 59 South (Sugar Land area) - Travel north on Hwy 59, exit 610 West Loop North at the Galleria. Travel on 610 North past I10 and the 290 split. Stay on 610 bearing right at the 290 split. Exit West TC Jester the first exit on the North Loop. Turn right at the traffic light (West TC Jester). Travel about one mile through a residential area, the clinic will be on the right.

From Hwy 59 North (Cleveland area) - Travel south on Hwy 59, exit 610 North Loop West. Travel West on 610. Exit East and West TC Jester. Turn left at the 2nd traffic light (West TC Jester). Travel under 610 over pass about one mile through a residential area, the clinic will be on the right.

From Hwy 290 East (Cypress area) - Travel southeast, exit 610 North Loop Exit East towards Downtown. Take the 1st exit on 610 East (West TC Jester). Turn right at the traffic light (West TC Jester). Travel about one mile through a residential area, the clinic will be on the right.

From Hwy 288 (Pearland area) - Travel north on Hwy 288, past 610 South Loop towards Downtown. Merge onto I45 North in Downtown Houston, exit 610 North Loop West. Travel West on 610. Exit East and West TC Jester. Turn left at the 2nd traffic light (West TC Jester). Travel under 610 over pass about one mile through a residential area, the clinic will be on the right.



From Hwy 225 (Pasadena/Deer Park area) - Travel west on Hwy 225, exit 610 Loop North and travel over the Ship Channel and past I10. Stay on 610 traveling North then West. Exit East and West TC Jester. Turn left at the 2nd traffic light (West TC Jester). Travel under 610 over pass about one mile through a residential area, the clinic will be on the right.

Personal Health History

Confidential

Houston Cosmetic Surgery Centers Confidential Patient Information

Patient Name:				Date:	
Address:				Apt:	
City, State				Zip:	
Email:				☐	Yes, sign me up f your email specia
Home Phone Primary contact ☐		Work Phone Primary contact ☐		Cell Phone Primary contact ☐	
Date of Birth:		Age:		Sex:	Male Female
SSN:		Marital Status:	S M D	Driver's Lic #:	State
Employer:		Address:			
Whom may we contact in case of EMERGENCY?					
Name:				Phone:	

How did you hear about us?

☐ Internet ☐ Newspaper ☐ Magazine ☐ Friend / Patient referral _____

☐ TV / Infomercial ☐ Billboards ☐ Radio ☐ Other _____

Insurance

Our clinics do not accept payment by insurance. Our receipts are formatted with all information necessary to submit for reimbursements. If you require a Pre Authorization we must receive the forms to complete three business days prior to your appointment.

Signature of Patient or Personal Representative _____ Date _____

Consent to Treat

I, the undersigned, hereby voluntarily consent and grant permission to HCSC, physician and employees to perform tests, treatment and any procedures as indicated at HCSC for myself or the above named minor, for as long as I am a patient at HCSC.

Signature of Patient or Personal Representative _____ Date _____

Occupational Hazard

In the event of an injury (i.e. needle stick) to an employee, that exposes any of my bodily fluids, at HCSC premises, I the undersigned, hereby voluntarily consent to give a blood specimen for testing.

Signature of Patient or Personal Representative _____ Date _____

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative _____ Date _____

Personal Health History

Confidential

Name:			Today's Date:
Age:	Date of Birth:	Date of Last Physical Examination:	

SYMPTOMS: Please circle Now, Past, or Never for each symptom.

GENERAL		GASTROINTESTINAL		EYE, EAR, NOSE, & THROAT		WOMEN ONLY	
Nervousness / Anxiety	Now / Past / Never	Appetite poor	Now / Past / Never	Bleeding gums	Now / Past / Never	Heavy men. bleeding	Now / Past / Never
Headache	Now / Past / Never	Bowel changes	Now / Past / Never	Blurred vision	Now / Past / Never	Irregular men. periods	Now / Past / Never
Depression	Now / Past / Never	Constipation	Now / Past / Never	Crossed eyes	Now / Past / Never	Abnormal Pap smear	Now / Past / Never
Dizziness	Now / Past / Never	Diarrhea	Now / Past / Never	Double vision	Now / Past / Never	Bleed between periods	Now / Past / Never
Fainting	Now / Past / Never	Difficulty swallowing	Now / Past / Never	Earache	Now / Past / Never	Breast lump	Now / Past / Never
Fever	Now / Past / Never	Excessive hunger	Now / Past / Never	Ear discharge	Now / Past / Never	Extreme menstrual pain	Now / Past / Never
Forgetfulness	Now / Past / Never	Excessive thirst	Now / Past / Never	Hay fever	Now / Past / Never	Hot flashes	Now / Past / Never
Loss of sleep	Now / Past / Never	Black stools	Now / Past / Never	Hoarseness	Now / Past / Never	Nipple discharge	Now / Past / Never
Sweats	Now / Past / Never	Hemorrhoids	Now / Past / Never	Loss of hearing	Now / Past / Never	Painful intercourse	Now / Past / Never
Loss of weight	Now / Past / Never	Indigestion	Now / Past / Never	Nosebleeds	Now / Past / Never	Vaginal discharge	Now / Past / Never
Numbness	Now / Past / Never	Nausea	Now / Past / Never	Ringing in ears	Now / Past / Never	Miscarriage	Now / Past / Never
		Rectal bleeding	Now / Past / Never	Sinus problems	Now / Past / Never	Date of last normal menstrual period?	
		Stomach pain	Now / Past / Never			Date of last Pap smear?	
		Vomiting	Now / Past / Never			Date of last Mammogram?	
		Vomiting blood	Now / Past / Never			Are you pregnant?	
						Number of children:	

MUSCLE / JOINT / BONE		CARDIO / PULMONARY		SKIN		MEN ONLY	
Pain, weakness, numbness in:		Chest pain	Now / Past / Never	Bruise easily	Now / Past / Never	Breast lump	Now / Past / Never
Arms	Now / Past / Never	Irregular heart beat	Now / Past / Never	Hives	Now / Past / Never	Erection difficulties	Now / Past / Never
Back	Now / Past / Never	Swelling of ankles	Now / Past / Never	Itching	Now / Past / Never	Lump in testicles	Now / Past / Never
Feet	Now / Past / Never	Shortness of breath	Now / Past / Never	Change in moles	Now / Past / Never	Penis discharge	Now / Past / Never
Hands	Now / Past / Never	Wheezing	Now / Past / Never	Rash	Now / Past / Never	Sore on penis	Now / Past / Never
Hips	Now / Past / Never	Persistent cough	Now / Past / Never	Sore that won't heal	Now / Past / Never	Other	Now / Past / Never
Legs	Now / Past / Never	Coughing blood	Now / Past / Never				
Neck	Now / Past / Never						
Shoulders	Now / Past / Never						

GENITO-URINARY							
Blood in urine	Now / Past / Never	Lack of bladder control	Now / Past / Never	Poor urinary stream	Now / Past / Never		
Frequent urination	Now / Past / Never	Painful urination	Now / Past / Never				

DIAGNOSES: Please circle Now, Past, or Never for each diagnoses.

AIDS	Now / Past / Never	Chemical dependency	Now / Past / Never	High cholesterol	Now / Past / Never	Psychiatric disorders	Now / Past / Never
Alcoholism	Now / Past / Never	Chicken pox	Now / Past / Never	High Blood Pressure	Now / Past / Never	Rheumatic fever	Now / Past / Never
Anemia	Now / Past / Never	Diabetes mellitus	Now / Past / Never	HIV positive	Now / Past / Never	Scarlet fever	Now / Past / Never
Anorexia	Now / Past / Never	Emphysema	Now / Past / Never	Kidney disease	Now / Past / Never	Stroke	Now / Past / Never
Arthritis	Now / Past / Never	Epilepsy / Seizures	Now / Past / Never	Measles	Now / Past / Never	Suicide attempt	Now / Past / Never
Asthma	Now / Past / Never	Glaucoma	Now / Past / Never	Migraine headaches	Now / Past / Never	Thyroid problems	Now / Past / Never
Bleeding disorders	Now / Past / Never	Goiter	Now / Past / Never	Mononucleosis	Now / Past / Never	Tonsillitis	Now / Past / Never
Breast lump	Now / Past / Never	Gonorrhea	Now / Past / Never	Multiple sclerosis	Now / Past / Never	Tuberculosis	Now / Past / Never
Bronchitis	Now / Past / Never	Gout	Now / Past / Never	Mumps	Now / Past / Never	Typhoid fever	Now / Past / Never
Bulimia	Now / Past / Never	Heart disease	Now / Past / Never	Pacemaker	Now / Past / Never	Ulcers – if yes, type	
Cancer	Now / Past / Never	Hepatitis	Now / Past / Never	Pneumonia	Now / Past / Never	Vaginal infection	Now / Past / Never
If yes, type:		Hernia – if yes, type		Polio	Now / Past / Never	Varicose veins	Now / Past / Never
Cataracts	Now / Past / Never	Herpes – if yes, type		Prostate problem	Now / Past / Never	Venereal disease	Now / Past / Never

MEDICATIONS: List medications you are currently taking		ALLERGIES: Medications or substances & symptoms experienced
Pharmacy Name:	Pharmacy Phone:	

Personal Health History

Confidential

HOSPITALIZATIONS or SURGERIES			PREGNANCY HISTORY		
Date	**Hospital**	**Reason for hospitalization/surgery**	**Year of**	**Boy or Girl**	**Outcomes / Type of Delivery**

Have you ever had a blood transfusion? Yes No **If yes, please give approximate dates:**

HEALTH HABITS Check (√) which substances you use and describe how much use			OCCUPATIONAL CONCERNS Check (√) if your work exposes you to the following	
	Caffeine			Stress
	Tobacco	(packs/day)		Hazardous substances
	Drugs			Heavy lifting
	Alcohol	(drinks/week)		Contact with blood or body fluids
	Other			Other

FAMILY HISTORY: Fill in health information about your family.

Relation	Age	State of Health	Age of Death	Cause of Death	Check (√) if your blood relatives had any of the following: Disease	Relationship to you
Father					Obesity	
Mother					Asthma, Hay fever	
Brothers					Cancer and type	
					Chemical dependency	
					Diabetes	
					Heart disease, Strokes	
Sisters					High blood pressure	
					Elevated cholesterol	
					other	

WEIGHT HISTORY: (Diet Patients Only)

Weight Loss Programs	Lowest Weight/Age		Highest Weight/Age		RESULTS COMMENTS
None					
Jenny Craig					
Weight Watchers					
Medical Weight					
Atkins					
Other					

I certify that the above information is correct and complete to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:		Date:	
Reviewed By:		Date:	