



PATIENT INFORMATION SHEET

Appointment Date: _____

Name: _____

Age: _____

Address: _____

Occupation: _____

Family Physician: _____ Dermatologist: _____

What area(s) of the face and/or body are you interested in having cosmetically or functionally improved?

- Forehead / Midface
- Lower Face / Neck
- Eyes
- Nose
- Chin
- Ears
- Skin Texture

- Breasts
- Abdomen
- Buttock
- Thighs
- Veins
- Hair
- Other _____

Description of facial/body concerns _____

Who referred you to us? _____

MEDICAL EVALUATION

List any medical conditions for which you are presently being treated. _____

List all drug /food /tape allergies:

List all medications you are taking, including prescription, over-the-counter, vitamins, and herbal supplements:

Are you or have you recently taken any medication containing Aspirin? Yes No

Please list name of medication and dosage: _____

Have you been on Accutane therapy in the last 18 months? Yes No

Have you taken any steroid preparations over the past year? Yes No

MEDICAL EVALUATION (continued)

Have you had significant weight change in the past year? Yes No

If Yes, _____ lbs loss _____ lbs gain

Height: _____ Current Weight: _____ Ideal Weight: _____

Exercise Frequency (check one): None 1x/week 2-3 x/week 4-6 x/week

Do you smoke cigarettes (cigar or pipe)? Yes No If yes, how much per day _____

Exposure to 2nd hand smoke on a daily basis? Yes No

Do you consume alcoholic beverages? Yes No If yes, how much per day _____

List all past surgeries (including cosmetic surgery) with dates:

Have you ever had any surgical complications? Yes No

Please describe: _____

Are you currently pregnant? Yes No

List dates of past pregnancies if any: _____

Is your family/significant other aware of your cosmetic concern(s)? Yes No

Does your family/significant other support your desire for cosmetic surgery or enhancement? Yes No

Please list any concerns or fears that you have or may have regarding your surgery or procedure.

What potential opportunities will having this surgery provide for you?

Please describe the strengths that you have that will make this procedure a success and positive experience for you.

If it was 1 year from now, and you were reflecting back to this day, what would have to happen both personally and professionally for you to be happy about your decision to have this procedure?

Are there any other questions or concerns you would like answered at this time?

MEDICAL EVALUATION (continued)

Please check all past and present medical conditions

CARDIOVASCULAR:

- High blood pressure
- Heart attack(s)
- Coronary artery disease
- Heart murmur/Mitral valve prolapse
- Irregular heartbeat/palpitations
- Stroke
- Peripheral vascular/arterial disease
- Blood clots

PULMONARY:

- Asthma
- Chronic lung disease
- Chronic cough
- Shortness of breath

HEMATOLOGICAL:

- Blood transfusion
- Bleeding disorder _____

NEUROMUSCULAR:

- Muscle weakness
- Nerve damage
- Facial paralysis/weakness
- Seizure disorder/convulsions
- Spinal/back disorders

PSYCHOLOGICAL:

- Depression
- Anxiety
- Claustrophobia
- Receive(d) psychiatric treatment
- Drug/alcohol dependency treatment
- Psychiatric hospitalization

NOSE:

- Nasal allergies
- Difficulty breathing by nose
- Previous nasal injury
- History of sinus infections

EYES:

- Dry eyes
- Blurred/double vision
- Cornea problems
- Glaucoma
- Thyroid eye disease
- Wear glasses/contacts

ENDOCRINE:

- Diabetes
- Thyroid disease

HEPATIC:

- Cirrhosis
- Hepatitis

RENAL:

- Dialysis
- Renal failure

GASTROINTESTINAL:

- Cholecystitis
- Colitis
- Pancreatitis
- Reflux disease
- Stomach ulcers

IMMUNOLOGICAL/INFECTIOUS DISEASES:

- HIV/AIDS
- TB
- Autoimmune disorder: _____

DERMATOLOGICAL:

- Cold sores / herpes
- Acne
- Rosacea
- Eczema
- Radiation to face/neck
- Scarring / keloid formation

CANCER:

- Breast cancer
- Family history of breast cancer
- Basal cell cancer _____
- Squamous cell cancer _____
- Melanoma _____
- Other cancer _____

OTHER CONDITIONS:
