



FACIAL PLASTIC SURGERY A S S O C I A T E S

1. Please specifically give the reason for your visit: _____

If your reason involves an injury or injuries, please describe the nature and give dates: _____

2. Please list all drug-related allergies or intolerances (or indicate none): _____

3. Are you under a doctor's care? _____ No _____ Yes NAME of physician: _____

PHONE: _____ ADDRESS: _____

Date of last complete physical examination _____

4. Have you ever seen an allergist? _____ No _____ Yes NAME of allergist: _____

PHONE: _____ ADDRESS: _____

6. Do you have (or have you had) any of the following ailments?

Please Circle Answer or Fill in Blank

PAST		PRESENTLY		PAST		PRESENTLY		Have you ever smoked? Yes No	
YES	NO	YES	NO	YES	NO	YES	NO	Do you currently use tobacco? Yes No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How many packs per day _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How long? _____ years	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol? Yes No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0-1 drinks per day _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2-3 drinks per day _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4+ drinks per day _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indicate if drugs or alcohol ever posed a	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dependency problem for you:	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Drugs _____ Alcohol	

7. List all medications you are currently taking (including over the counter medicines, aspirin or aspirin containing medicines, birth control pills, diet pills, Vitamin E, or herbal preparations), along with the dosage and frequency: _____

8. List all previous operations or major illnesses and all hospitalizations you have had, along with approximate dates: _____

	YES	NO
9. Have you had exposure to HIV through prior sexual history, surgery, transfusions or IV drug use?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a reaction to anesthetics?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of increased bleeding tendency?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been under the care of a psychiatrist?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a nervous breakdown?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>
Are your glasses just for reading?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contacts?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of bad scarring?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, where? _____		

Have you had a Botox Injection? _____

If so, give date: _____

If so, give location on your face: _____

10. Family History	YES	NO	YES	NO
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Family Estrangements	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attacks	<input type="checkbox"/>
Bleeding Tendencies	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Breakdown	<input type="checkbox"/>
Congenital Defects	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Strokes	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Suicide	<input type="checkbox"/>

HEIGHT: _____ WEIGHT: _____

This information is correct and complete to the best of my knowledge, and I give my permission for you to contact and communicate with my physicians and insurance company.

(Signature) _____

(Date) _____ / _____ / _____

PT. ID #

PT. NAME: