Clear Form

Patient Name: Date of Birth:

HAVE YOU EVER HAD:	YES	NO
High blood pressure?	☐	☐
Irregular heartbeat or Pacemaker?	☐	☐
Heart Disease/Angina/Mitral valve prolapse?	☐	☐
Kidney Disorders?	☐	☐
Diabetes?	☐	☐
Lung or respiratory disease?	☐	☐
Tuberculosis (TB)?	☐	☐
Asthma?	☐	☐
Arthritis/Joint disease?	☐	☐
Hepatitis/Liver disease?	☐	☐
Stomach trouble (including ulcers)?	☐	☐
Thyroid dysfunction?	☐	☐
Anemia/Blood Disorder?	☐	☐
AIDS/HIV +?	☐	☐
Depression/anxiety/panic attacks?	☐	☐
Are you currently under psychiatric care?	☐	☐
Have you ever had an injury to your head, face or neck?	☐	☐
Cancer (including skin cancer)? Site(s):	☐	☐
Have you ever had chemotherapy or radiation?	☐	☐
Do you smoke? How much?	☐	☐
Do you drink alcohol? How much?	☐	☐
Do you require treatment for hay fever or other allergies?	☐	☐
Do you have difficulty breathing through your nose or shortness of breath?	☐	☐
Do you have frequent nosebleeds or bruise easily?	☐	☐
Do you have any skin disease (cold sores, herpes, eczema, psoriasis, acne, fever blisters, dermatitis)? If yes, please specify:	☐	☐
Are you allergic to adhesive tape, iodine or any cosmetics?	☐	☐
Have you ever received local anesthesia from a doctor or dentist?	☐	☐
Did you have an adverse reaction?	☐	☐
WOMEN: Do you suspect you might be pregnant?	☐	☐

Last menstrual period

Please explain any "yes" answers

Please list any other medical problems or serious illnesses you may have:

List all prior surgery:

ARE YOU BEING SEEN FOR A COSMETIC CONSULTATION ??
Complete this section ONLY if answer is YES ☐ YES ☐ NO

Do you plan to gain or lose more than 10 lbs? ☐ ☐
Current wt. Wt. 1 year ago
Do you exercise regularly? ☐ ☐
How long have you been thinking about having plastic surgery?
Have you had plastic surgery before? ☐ ☐
If yes, what was done and when?
Were you happy with the results? ☐ ☐
Eye disease, including glaucoma or "dry eyes"? Please specify: ☐ ☐
Have you ever had any other surgery to your head, face or neck? ☐ ☐
How do you think plastic surgery will benefit you?
Do you think plastic surgery will significantly change your life? ☐ ☐
If yes, in what way?

Which of the following are you interested in improving?

☐ Nose ☐ Hair
☐ Breathing ☐ Appearance ☐ Scars
☐ Chin ☐ Acne ☐ Other
☐ Eyelids ☐ Ears
☐ Forehead/Brow ☐ Wrinkles
☐ Face (Facelift) ☐ Facial Blemish
☐ Cheek, Lips (Mole, etc)
☐ Other:

Please list all your current medications, including dose.
(Remember to include aspirin, Advil, birth control pills and hormones, steroids, heart and asthma medications, blood thinners, antidepressants and vitamins.)

Describe allergic reactions to medications you may have had:

☐ Penicillin
☐ Amoxicillin/Augmentin
☐ Erythromycin
☐ Cipro
☐ Sulfa drugs
☐ Local Anesthetic
☐ Aspirin
☐ Codeine
☐ Other

☐ **To my knowledge, I have NEVER had an allergic reaction to any medications both prescribed and over the counter.**

X _____ / / _____

Patient Signature / Guardian *Date*

Print Form!