

INFORMATION SHEET

Name: _____ Age: _____ Birthdate: _____ Occupation: _____

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

Family physician: _____ Phone #: _____

When was your last physician exam? _____

Dermatologist: _____ Phone #: _____

Ophthalmologist: _____ Phone #: _____

Cardiologist: _____ Phone #: _____

MEDICAL EVALUATION

How is your general health? _____

List any medications you are presently taking:

Name	Dose

Are you taking vitamins? NO YES What? _____

Are you taking aspirin or medication containing aspirin? _____ Dosage _____

Have you taken any steroid preparations over the past year? _____

Have you taken any Accutane therapy over the past 18 months? _____

List all past surgeries:

Type of Surgery	Date

Did you ever have any complication of surgery? NO YES What? _____

Did you or a family member have any complications from anesthesia? NO YES Who? _____

What? _____

Do you require antibiotics before a procedure? NO YES What? _____

ALLERGIES

List any drug allergies (including local anesthetics and codeine)

Other allergies: Tape _____ Latex _____ Environmental _____ Food _____

PLEASE COMPLETE ALL OF THE FOLLOWING QUESTIONS:

EYE

- | | | |
|-------------------------------------------------------------|------------------------------|-----------------------------|
| Visual loss (one or both eyes) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| “Dry” eyes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Itching or irritation of eyes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blurred or double vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Crossed or lazy eyes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cornea problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thyroid eye disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Wear glasses or contacts | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Previous eye or eyelid surgery (<i>if yes, what type</i>) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
-

NOSE

- | | | |
|---------------------------------------------------------------|------------------------------|-----------------------------|
| Difficulty breathing through nose | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Previous injury to nose | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nasal allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nose bleeds | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sinus conditions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Previous nasal or sinus surgery (<i>If yes, what type?</i>) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
-

FACE/NECK

- | | | |
|-------------------------------------------------------------|------------------------------|-----------------------------|
| Irradiation to face or neck | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Facial paralysis or weakness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Facial skin problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| History of cold sores | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Previous face or neck surgery (<i>If yes, what type?</i>) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
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CARDIOVASCULAR

- | | | |
|--------------------------------------|------------------------------|-----------------------------|
| Coronary or heart attack | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Congenital heart disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Congestive heart failure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Palpitations or irregular heart beat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hypertension | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mitral valve prolapse | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pacemaker or defibrillator | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
-

CHEST

- | | | |
|----------------------|------------------------------|-----------------------------|
| Shortness of breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chronic lung disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chronic cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
-

PSYCHIATRIC

- | | | |
|------------------------------------------------------------|------------------------------|-----------------------------|
| Have you received psychiatric treatment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| (<i>If yes, were you hospitalized?</i>) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has there been any recent crisis in your life? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been treated for drug or alcohol dependency? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have claustrophobia? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

OTHER

- History of stomach problems or ulcer? Yes No
- History of thyroid problems? Yes No
- History of seizure disorder, convulsions or paralysis? Yes No
- Communicable disease such as tuberculosis? Yes No
- Liver disorder including hepatitis or cirrhosis? Yes No
- Kidney or bladder disorders or chronic infections? Yes No
- Spinal or back disorders? Yes No
- Previous blood clots or thrombophlebitis? Yes No
- Any bleeding disorders in self or family? Yes No
- Blood transfusion? Yes No
- Diabetes? Yes No
- Autoimmune disease?
(Lupus, rheumatoid arthritis, etc.)? Yes No
- Any unusual scarring or keloid formation? Yes No
- If applicable, are you pregnant? Yes No
- Implants or Medical Devices?
(e.g. knee replacement, hip replacement, plates, screws etc.) Yes No

SOCIAL

- Do you smoke? Yes No
- If yes, how many packs a day? _____
- Do you drink more than two drinks per day? Yes No
- Have you discussed this surgery with your family? Yes No
- If yes, are they agreeable? Yes No

MAILINGS

- Would you like to be on our mailing list? Yes No

List below any questions you would like to have specifically answered during your consultation.

How did you hear about us? (circle and/or fill in name)

Mailings Radio Newspaper/Magazine: _____ Website/Internet: _____

Family/Friend: _____ Physician: _____ Other: _____

Signature Date