

## PATIENT INFORMATION & EVALUATION SHEET

Patients are required to stop using any aspirin-containing medications, nonsteroidal anti-inflammatory drugs, alcohol, and particularly tobacco for 2 weeks before and after the operation. Additionally, certain vitamins and the newer herbal remedies, such as vitamin E or ginkgo biloba, are discontinued during this period as well. Preoperative medications include vitamin C to enhance healing in the early postoperative period.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Email: \_\_\_\_\_

How did you first hear about us? \_\_\_\_\_

Were you referred by someone, if so, who? \_\_\_\_\_

May we send a thank-you referral letter to them? \_\_\_\_\_

What area(s) of the face are you interested in having improved? \_\_\_\_\_

What motivated you to come see us today? \_\_\_\_\_

What are your concerns you would like to discuss? \_\_\_\_\_

How long have you been considering cosmetic enhancement? \_\_\_\_\_

What are your cosmetic goals? \_\_\_\_\_

List skin care products you currently use \_\_\_\_\_

My surgical time frame is: ASAP \_\_\_\_\_ Soon \_\_\_\_\_ 1-3 months \_\_\_\_\_

I have determined a budget for my care: Yes \_\_\_ No \_\_\_ Estimate: \$ \_\_\_\_\_

### **MEDICAL EVALUATION (General)**

How is your general health? \_\_\_\_\_

Are you presently being treated for any medical conditions? \_\_\_\_\_

When was your last physical examination? \_\_\_\_\_

\_\_\_\_\_

**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 problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wear glasses or contacts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Previous eye or eyelid surgery (if yes, what type)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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**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 (if yes, what type)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Previous face or neck surgery (if yes, what type)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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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

**CARDIOVASCULAR**

Coronary or heart attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital heart disease	<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

**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 ever received psychiatric treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, were you hospitalized?	<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 been treated for drug or alcohol dependency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**OTHER**

Liver disorder including hepatitis or cirrhosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney or bladder disorders or chronic infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spinal or back disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Previous blood clots or thrombophlebitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any bleeding disorders in self or family	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Autoimmune disease (e.g. lupus, rheum arthritis)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any unusual scarring or keloid formation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If applicable, are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**ALLERGIES**

Any drug allergies

(Including local anesthetics & codeine)       Yes       No

If yes, please list drug and reaction type \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tape allergy       Yes       No

**MEDICATION**

List any medications you are currently taking and dosage (within the last month)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you taking aspirin or medication containing aspirin?       Yes       No

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

**SOCIAL**

Do you smoke?       Yes       No

If so, how many packs a day? \_\_\_\_\_

Do you drink more than 2 drinks per day?       Yes       No

Do you feel for any reason you may be at risk for AIDS?       Yes       No

\_\_\_\_\_  
Signature

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_