



New Patient Questionnaire

Please help us help you by completing this questionnaire. By providing us with the following information we will be able to make your visit with us a productive and enjoyable experience. We respect your privacy and all information will be kept confidential.

Name: _____ Date: _____

1. What is your primary reason you are here?

2. Name up to three aesthetic changes to your face you would like to address?
 - 1.
 - 2.
 - 3.

3. What are your concerns or road blocks to having a procedure?

4. What are your short-term and long-term goals?

5. Have you had any experience with plastic surgery in the past? If so explain.

6. Have you visited other doctors for consultation regarding any of the above reasons?

7. What were their comments and/or recommendations?

8. How likely is it that you would be satisfied with improvement and not “perfection”?

Thank you for completing this information as completely and honestly as possible.

Signature: _____

Past Medical History Questionnaire



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

Personal Physician | Are you under a doctor's care? Y N
 Name of physician _____ Phone #: _____
 Address: _____
 Date of last complete physical exam: _____

Medical | What medical conditions are you currently being treated for?
 Do you have (or have you had) any of the following ailments?

	YES	NO		YES	NO
Prolonged bleeding when cut	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or blackout episodes	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	+HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease or heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur or irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain or shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>

If you are considering nasal surgery:
 Do you have (or have you had) any of the following symptoms?

	YES	NO		YES	NO
Difficulty breathing through nose	<input type="checkbox"/>	<input type="checkbox"/>	Nasal allergies	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infections	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Excessive crusting	<input type="checkbox"/>	<input type="checkbox"/>	Whistling sound through nose	<input type="checkbox"/>	<input type="checkbox"/>

Surgical | Please list all previous operation(s) and the date(s) of the surgery

Allergies | Are you allergic or have any sensitivities to medications, drugs, or local anesthetics or medications?
If so please list the name(s) of the medications, your body's reaction, and the date of the reaction

Medications | List all medications you are currently taking (including over-the-counter medications, aspirin, herbal medications, vitamin E, birth control pills):

MEDICATION	DOSE	FREQUENCY TAKEN
_____	_____	_____
_____	_____	_____
_____	_____	_____

Scarring | Have you formed excessive or unsatisfactory scars in the past (keloids or hypertrophic scars)? YES NO

Social history | Do you smoke? NO YES, _____ packs per day.
 Do you drink alcohol? NO OCCASIONALLY REGULARLY _____ drinks/day
 Have drugs or alcohol ever posed a dependency problem for you? NO YES

Family History | Is there a history of the following in your immediate family? If so, please list the family member beside the disease.

	YES	NO		YES	NO
Alcoholism _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (type) _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis _____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke _____	<input type="checkbox"/>	<input type="checkbox"/>
Suicide _____	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure _____	<input type="checkbox"/>	<input type="checkbox"/>

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

Signature _____

Date ____/____/____