WestShore Facial Cosmetic Surgery

Candidate for Facial Cosmetic Surgery

Patient Health History

Date:_______________

Name:____ **Circle one:** Full Time Seasonal
(First) (Middle) (Last)

Birth Date: ______________________ Sex: F M **Circle one:** Single Married Divorced Widowed

Address:____
(Street) (City) (State) (Zip)

Home # ( ) _______ - __________ Cell # ( ) _______ - __________ Other # ( ) _______ - __________

May we contact you at your home phone? Yes No Contact Name:_______________

Email: ____________________________________ Employer: ____________________________________

Referred by: _________________________________ Employer Phone: ( ) ___________________________

May we contact you at work? Yes No

So we can better help you meet your goals, please take a moment & answer the following questions:

What is your primary concern about your face? ____

What are the top 3 things about your face that bother you? 1.______________________________

2. ____________________________________ 3.____________________________________

How much time are you able to take off for post-op & recovery? ____________________________

Do you have any big events planned (ex: Wedding, Reunions, Parties)?________________________

How much are you willing to invest? ____$500-$1,000 ____$1,000-$5,000 ____$5,000-10,000 ____$10,000 +

Please take a few moments to check any of the following areas you would like to discuss with Dr Reed:

______ Aging of the Face/Neck
______ Sun Damaged Skin
______ Unwanted Fat Deposits
______ Nose Shape
______ Snoring
______ Skin Care
______ Facial Lines or Wrinkles
______ Cheek/Chin Shape/Size
______ Age Spots
______ Skin Cancer
______ Nasal Beathing
______ Sleep Apnea
______ Eyelid Lifting
______ Facial Peels
______ Liposuction
______ Laser Treatment
______ Brow Shape or Size
______ Botox
______ Aesthetic Injectables
______ Dermabrasion
______ Scar Revision

Please note if you <u>have</u>, or <u>have had</u>, any of the following:

____ Lung Disease
____ Asthma
____ High Blood Pressure
____ Stroke
____ Muscle Problems
____ Heart Disease
____ Abnormal Bleeding
____ Immune Deficiency Disease
____ Alcohol Abuse
____ Arthritis
____ Artificial Joints
____ Artificial Heart Valves
____ Chicken Pox
____ Colitis or Crohn's Disease
____ Diabetes
____ Anemia
____ Bleeding Disorder
____ Skin Cancer
____ Difficulty Breathing
____ Drug Abuse
____ Emphysema
____ Epilepsy
____ Fainting Spells
____ Fever Blisters
____ Frequent Headaches
____ Glaucoma
____ Hay Fever
____ Hemophilia
____ Rheumatic Fever
____ Scarlet Fever
____ Seizures
____ Shingles
____ Sickle Cell Disease
____ Sinus Problems
____ Thyroid Problems
____ Tonsillitis
____ Tuberculosis
____ Ulcers
____ Venereal Disease

Please list any other conditions:____
____

Please list any significant problems of immediate family:

Mother: ______________________________
Father: ______________________________
Brothers: ______________________________
Sisters: ______________________________

Date of your last physical exam: ______________________________
Are you currently under the care of a personal physician? Yes No
Reason: ______________________________
____
____
Physician's Name: ______________________________
Physician's Phone #: ______________________________

Please list any prior surgeries and their dates: ______________________________
____
____

Do you wear glasses or contacts? Yes No
Do you wear dentures? Yes No
Do you bleed excessive after a cut? Yes No

Do you form keloids? Yes No
Do you get frequent infections? Yes No

If you answered yes to any of the above questions, please describe: ______________________________
____
____

Are you allergic to any foods or medications? Yes No If yes, please describe: ______________________________
____

List all medications you are taking at the present time, including non-prescription, with doses and frequency:
1.______________ 3.______________ 5.______________
2.______________ 4.______________ 6.______________

Are you allergic to latex? Yes No
Do you take aspirin or aspirin compounds? Yes No
Have you ever taken Phen-Fen? Yes No
Have you ever taken Accutane for acne? Yes No
Do you smoke or chew tobacco? Yes No

For Women Only
Are you pregnant:? Yes No Unsure
Do you take birth control pills? Yes No
# of pregnancies___ # of Children _____
Date of last Mammogram? ______________

PLEASE NOTE: It is strongly recommended that any patient who smokes or uses tobacco stop all use for a minimum of TWO WEEKS prior to any facial cosmetic surgical procedure. Smoking will slow down the healing process and if you think you are unable to stop smoking, please tell us.

Please initial below:

________ I can stop smoking and using tobacco for the period of time required

________ I can ***not*** stop smoking and using tobacco for the period of time required

I acknowledge and I certify that the above information is correct. I understand that my information will be kept in strict confidence and it is my responsibility to inform the office & Dr Eric Reed of any changes in my medical status.

______________________ ______________________________
Date *Patient/Guardian Signature*