

INFORMATION SHEET

Name: _____ Birthday: _____ Age: _____

Occupation: _____

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

Family physician: _____

Phone number: _____

Address: _____ When was your last physician exam? _____

Dermatologist: _____ Address: _____

Ophthalmologist: _____ Address: _____

MEDICAL EVALUATION

How is your general health? _____

List any medications you are presently taking and dosage _____

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 with dates _____

Did you ever have any complication of surgery? _____ What? _____

ALLERGIES

List any drug allergies (including local anesthetics and codeine) _____

Other allergies: Tape _____ Latex _____ Environmental _____

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 |

| | | |
|---|------------------------------|-----------------------------|
| Previous face or neck surgery (<i>If yes, what type?</i>) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|------------------------------|-----------------------------|

| | | |
|------------------------------|------------------------------|-----------------------------|
| 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 |

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 |

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

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.

Who referred you to us? _____

Address, if know _____

Signature