

**FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY  
NEW PATIENT INFORMATION SHEET**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Occupation: \_\_\_\_\_

What is the reason for your visit: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Cardiologist: \_\_\_\_\_ Phone #: \_\_\_\_\_

Dermatologist: \_\_\_\_\_ Phone #: \_\_\_\_\_

Pharmacy Name, Location and Phone Number: \_\_\_\_\_

**ALLERGIES**

List any drug, tape, or latex allergies (including local anesthetics and codeine)


**LIST ANY MEDICATIONS YOU ARE TAKING:** (attach list if necessary)

Name	Dose

Are you taking any aspirin or medication containing aspirin: \_\_\_\_\_ Dose: \_\_\_\_\_

Do you require antibiotics before a procedure? NO YES What? \_\_\_\_\_

Do you have any implants or medical devices? NO YES What? \_\_\_\_\_  
(knee replacement, hip replacement, plates/screws, etc)

**PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:**

- |  |     |                          |    |                          |
|--|-----|--------------------------|----|--------------------------|
| Cardiac Condition(s) or History of Cardiac Condition           | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Coronary or heart attack                                       | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Heart Murmur or Mitral valve prolapse                          | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Pacemaker or defibrillator                                     | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Hypertension   | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Stroke or TIA  | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Communicable diseases (Tuberculosis, hepatitis, HIV, or MRSA)  | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Previous blood clots or thrombophlebitis                       | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Pulmonary Conditions (Asthma, COPD)                            | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Diabetes   | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| History of cold sores  | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Do you smoke? How much _____                                   | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Do you drink more than 2 drinks per day? If so, how much _____ | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| If applicable, are you pregnant?                               | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |

Signature \_\_\_\_\_

Date \_\_\_\_\_