FACIAL PLASTIC SURGERY ASSOCIATES

1. Please specifically give the reason for your visit:

If your reason involves an injury or injuries, please describe the nature and give dates:

2. Please list all drug-related allergies or intolerances (or indicate none).

3. Are you under a doctor's care? YES ☐ NO ☐

NAME OF PHYSICIAN | **PHONE**

ADDRESS [CITY/STATE/ZIP]

Date of last complete physical examination?

4. Have you ever seen an allergist? YES ☐ NO ☐

NAME OF ALLERGIST

5. List all medications you are currently taking, along with the dosage and frequency:
(including over the counter medicines, aspirin or medicines containing aspirin, birth control pills, diet pills, Vitamin E, or herbal preparations)

6. List all previous operations or major illnesses and all hospitalizations you have had, along with dates.

7. Have you had a Botox Injection? YES ☐ NO ☐

WHEN | **WHERE**

FAMILY HISTORY

Alcoholism	YES ☐ NO ☐	High Blood Pressure	YES ☐ NO ☐	Diabetes	YES ☐ NO ☐
Family Estrangements	YES ☐ NO ☐	Cancer	YES ☐ NO ☐	Strokes	YES ☐ NO ☐
Allergies	YES ☐ NO ☐	Nervous Breakdown	YES ☐ NO ☐	Epilepsy	YES ☐ NO ☐
Heart Attacks	YES ☐ NO ☐	Congenital Defects	YES ☐ NO ☐	Suicide	YES ☐ NO ☐
Bleeding Tendencies	YES ☐ NO ☐	Stomach Problems	YES ☐ NO ☐		

HEIGHT | **WEIGHT**

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

NAME | **DATE**

Thank You for Choosing FPSA

S:Administration\2011Forms\PtHistory

GENERAL PATIENT HISTORY

Do you have (or have you had)any of the following?

PAST YES	PAST NO		PRESENT YES	PRESENT NO
☐	☐	Nasal Allergy	☐	☐
☐	☐	Post-Nasal Discharge	☐	☐
☐	☐	Sinus Infections	☐	☐
☐	☐	Nose Bleeds	☐	☐
☐	☐	Headaches	☐	☐
☐	☐	Hepatitis	☐	☐
☐	☐	Difficulty Breathing Through Nose	☐	☐
☐	☐	Sleep Apnea	☐	☐
☐	☐	Do You Use a CPAP	☐	☐
☐	☐	Heart Trouble	☐	☐
☐	☐	Mitral Valve Prolapse	☐	☐
☐	☐	Diabetes	☐	☐
☐	☐	Ulcers	☐	☐
☐	☐	Anemia	☐	☐
☐	☐	Asthma	☐	☐
☐	☐	Pulmonary Trouble	☐	☐
☐	☐	High Blood Pressure	☐	☐
☐	☐	+HIV/AIDS	☐	☐

Have you ever smoked? YES ☐ NO ☐

Do you currently use tobacco? YES ☐ NO ☐

How many packs a day?

How many years?

Do you drink alcohol? YES ☐ NO ☐

How many drinks per day?

Indicated if drugs or alcohol posed a dependency problem for you: DRUGS ☐ ALCOHOL ☐

Have you had exposure to HIV through prior sexual history, surgery, transfusions or IV drug use? YES ☐ NO ☐

Have you had a reaction to anesthetics? YES ☐ NO ☐

Do you have a history of increased bleeding tendency? YES ☐ NO ☐

Have you ever had a blood transfusion? YES ☐ NO ☐

Have you ever been under the care of a psychiatrist? YES ☐ NO ☐

Have you ever had a nervous break-down? YES ☐ NO ☐

Do you wear glasses? YES ☐ NO ☐

Are your glasses just for reading? YES ☐ NO ☐

Do you wear contacts? YES ☐ NO ☐

Do you have a history of bad scarring? If yes, where? YES ☐ NO ☐