COMMONWEALTH
FACIAL PLASTIC SURGERY

Date:______________

Name____ Date of Birth___________________________________Age____________

Occupation____ Employer____

How did you hear about us?____________________________________Who may we thank for referring you?___________________________

Please specifically give the reason for your visit: ____

Do you have any interest in facial plastic/cosmetic surgery?: ____

Do you have any interest in **Latisse**? ☐Yes ☐No

Do you currently have, or have you ever been treated for any of the following conditions:

- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
  Type:__________
- ☐ COPD or emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Gastroesophageal Reflux
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Irregular Heartbeat
- ☐ Kidney Stones
- ☐ Latex Allergy
- ☐ Low Blood Sugar
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ MRSA
- ☐ Nasal Obstruction
- ☐ Pneumonia
- ☐ Rheumatoid Arthritis
- ☐ Sickle Cell Disease
- ☐ Sleep Apnea
  ☐CPAP
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Other:_____________

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In the past 6 months, have you experienced:

☐Weight loss	☐Chest Pain	☐Joint Pain
☐Nausea/Vomiting	☐Shortness of breath	☐Headaches
☐Fever/Chills	☐Nasal Obstruction	☐Depression
☐Night Sweats	☐Muscle weakness	☐Sore throat
☐Fatigue	☐Difficulty Swallowing	☐Heartburn

Social History

Do you currently use tobacco? ☐Yes ☐No

Packs per day __________ How long? _______ years

If you smoked previously, when did you quit? _________

Do you drink alcohol? ☐Yes ☐No

Indicate if drugs or alcohol ever posed a dependency problem for you: ____ Drugs _____ Alcohol

SURGERIES ☐**Check if none**

List all surgeries you have had, including childhood surgeries such as tonsillectomy or ear tubes:

Surgery	Date	Surgeon/hospital

MEDICATIONS ☐**Check if none**

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

Medication	Dosage	Duration (How long?)

ALLERGIES TO MEDICATIONS ☐**Check if none**

List any medications to which you are allergic:

Medication	Type of reaction

Do you or anyone in your immediate family have a history of bleeding problems? ☐No ☐Yes: explain__________________________________

Do you or anyone in your immediate family have a history of anesthesia reactions? ☐No ☐Yes: explain__________________________________

Do you have a history of bad scarring? ☐No ☐Yes: explain__________________________________

Are you pregnant or nursing? ☐No ☐Yes

For office use

☐ Entered in EMR