THE PALM BEACH CENTER
for Facial Plastic & Laser Surgery

PATIENT INFORMATION SHEET

NAME: ________________________________

DATE: ________________________________

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

_____ Forehead / Midface _____ Lower Face / Neck _____ Eyes _____ Skin Texture

_____ Nose _____ Chin _____ Ears _____ Other: ________________________

Description of facial/body concerns: ____

____

Is your family/significant other aware of your cosmetic concerns? ______ yes ______ no

Does your family/significant other support your desire for cosmetic surgery or enhancement? _____ yes _____ no

Please check any fears you have regarding surgery/medical procedures:

_____ Anesthesia _____ Surgical outcome _____ Opinion of others _____ Unsuccessful past procedures

_____ Pain _____ Cost _____ Recovery time _____ Complications ______ Natural-looking results

_____ Current medical issues _____ Other: ____

Please check the strengths you possess that will make this procedure a success for you:

_____ Positive outlook _____ Personal motivation _____ Support from significant other _____ Self-confident

_____ Family support _____ Successful career _____ Disciplined, goal-oriented _____ Confidence in surgeon

_____ Good timing for procedure, i.e.: retirement _____ Other: ____

Please check the potential opportunities having a procedure/surgery will provide for you:

_____ Improved self-esteem _____ Improved self-confidence _____ Advancement in career/career change

_____ Getting married _____ New relationship opportunities _____ Correction of cosmetic flaws

_____ Physical appearance reflect mental image of self _____ Increased comfort with intimacy

_____ Life event, i.e.: child's wedding, school reunion _____ Other: ______________________________________

Are there any questions or concerns you would like answered at this time? ________________________________

MEDICAL EVALUATION
Please check all past and present medical conditions.

CARDIOVASCULAR:
____ High blood pressure
____ High cholesterol
____ Coronary artery disease
____ Heart attack(s)
____ Stent placement
____ Irregular beat/Palpitations
____ Murmur/Valve prolapse
____ Peripheral vascular disease
____ Pacemaker
____ Abnormal EKG
____ Stroke/TIA(s)

PULMONARY:
____ Asthma
____ Shortness of breath
____ Chronic cough
____ Chronic lung disease
____ Home oxygen use
____ Sleep apnea/CPAP

HEMATOLOGICAL:
____ History of blood clots
____ Anemia
____ Bleeding/Clotting disorder
____ Blood transfusion

NEUROLOGICAL:
____ Nerve damage
____ Facial paralysis/weakness
____ Seizure disorder/convulsions
____ Spinal/Back disorder
____ Dizziness/Vertigo
____ Peripheral neuropathy
____ Migraine headaches

PSYCHIATRIC:
____ Anxiety
____ Depression
____ Bipolar disorder
____ Claustrophobia
____ Body dysmorphia
____ Received psychiatric treatment/hospitalization
____ Drug/alcohol dependency
____ Dementia Alzheimer's

MUSCULOSKELTAL:
____ Muscle weakness
____ Rheumatoid arthritis
____ Osteoarthritis
____ Degenerative joint disease
____ Osteoporosis

ENDOCRINE:
____ Diabetes
Type 1 Type 2
____ Insulin dependent
____ Hypoglycemia
____ Thyroid disease

EYES/EARS/NOSE/THROAT:
____ Glasses/contacts
____ Blurred/double vision
____ Cornea problems
____ Glaucoma
____ Cataracts
____ Thyroid disease
____ Dry eyes
____ Hearing loss: R L
____ Hearing aids: R L
____ Difficulty breathing by nose
____ Nasal allergies
____ Frequent sinus infections
____ Previous nasal injury
____ Dentures/Oral appliance

GASTROINTESTINAL:
____ Heartburn/GERD
____ Ulcers
____ Irritable bowl disease
____ Diarrhea
____ Constipation
____ Crohns/Colitis
____ Pancreatitis

ONCOLOGICAL:
____ Breast cancer
____ Basal cell cancer – site: ______________________________
____ Squamous cell cancer – site: _________________________
____ Melanoma – site: _____________________________________
____ Other cancer – site: ___________________________________

RENAL/GU:
____ Kidney disease/failure
____ Dialysis
____ Kidney stones
____ Frequent UTIs
____ Enlarged prostate

DERMATOLOGICAL:
____ Cold sores/herpes
____ Rosacea
____ Radiation to face/neck
____ Scarring/keloid formation
____ Acne
____ Eczena
____ Psoriasis

IMMUNOLOGICAL/ INFECTIONS DISEASES:
____ Autoimmune disorder: ________________________
____ Tuberculosis
____ HIV/AIDS
____ STD

REPRODUCTIVE:
____ Pregnant
____ Breastfeeding
____ Past pregnancies: # ____
____ C-section(s)
____ Contraception use:
Type: __________________
____ Pre/Post menopause

HEPATIC:
____ Cholecystitis
____ Cirrhosis
____ Hepatitis

List all drug / food / environmental / tape allergies:

______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________

List all medications you are taking, including prescription, over-the-counter, vitamins, and herbal supplements:

______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________

Are you or have you recently taken any medication containing Aspirin? _____ yes _____ no

Please list name of medication and dosage: ____

Have you been on Accutane therapy in the last 18 months? _____ yes _____ no

Have you taken any steroid preparations over the past year? _____ yes _____ no

List all past surgeries (including cosmetic surgery) with year:

_____________________________ _______________________________ ______________________________
_____________________________ _______________________________ ______________________________
_____________________________ _______________________________ ______________________________

Have you ever had any surgical complications? _____ yes _____ no
Please describe: ____
____

Height: __________________ Weight: ___________________ Ideal weight (if not at ideal): ____________

Exercise Frequency (check one): _____ ≤ 1x/week _____ 2-4x/week _____ 5-7x/week

Marital Status: _____ Single _____ Long-term partner _____ Married _____ Divorced _____Widow(er)

Are you currently pregnant or breastfeeding? _____ yes _____ no
List delivery dates of past pregnancies: ____

Do you use nicotine products? _____ yes _____ no If yes, how much per day: ___________________________

Did you ever smoke? _____ yes _____ no For how many years:__________ Year you quit: __________

Exposure to 2nd hand smoke on a daily basis? _____ yes _____ no

Do you consume alcoholic beverages? _____ yes _____ no

Race: _____ Asian/Pacific Islander _____ African American _____ Caucasian _____ Hispanic or Latino
_____ Middle Eastern/Arab _____ Native American

Ethnicity: ____

Primary Language Spoken: _____ English _____ Spanish _____ French _____ Other: ____________________

FAMILY HISTORY

	Condition	Afflicted Family Member(s)	Comments
	Adopted		
	Abnormal bleeding/clotting		
	Anesthesia problems		
	Autoimmune disorder		
	Cancer		
	Cleft lip/palate		
	Diabetes		
	Hearing loss		
	Heart disease		
	High blood pressure		
	Kidney disease		
	Liver disease		
	Skin disease		
	Substance Abuse		