DILIPDMADNANIMDFACS
FACIAL PLASTIC SURGERY • NATURAL RESULTS

Medical History

Patient Name : _____ Today's Date: ____/____/____

Please answer the following questions

Are you able to walk up a flight of stairs with a bag of groceries?			□ **Yes** □ **No**
Are you currently pregnant?			□ **Yes** □ **No**
Have you ever had radiation therapy or chemotherapy for cancer?			□ **Yes** □ **No**
Have you ever had a connective tissuse disorder such as Ehlers Danlos Syndrome, Lupus, Scleroderma,Rheumatoid Arthritis, Wegener's Disease or Sarcoidosis? Have you had facial involvement ?_____			□ **Yes** □ **No**
Have you had surgery of the face or neck within the previous 6 months?			□ **Yes** □ **No**
Oxygen dependent COPD or severe asthma?			□ **Yes** □ **No**
Bleeding Disorder**?**	□ **Yes** □ **No**	Brain aneurysm or brain shunt	□ **Yes** □ **No**
Abnormal Scarring?	□ **Yes** □ **No**	Obstructive sleep apnea ?	□ **Yes** □ **No**
Reaction to latex**?**	□ **Yes** □ **No**	Restless Leg Syndrome ?	□ **Yes** □ **No**
Lidocaine allergy?	□ **Yes** □ **No**	HIV/AIDS ?	□ **Yes** □ **No**
Epinephrine sensitive?	□ **Yes** □ **No**	Kidney Insufficiency ?	□ **Yes** □ **No**
Diabetes ?	□ **Yes** □ **No**	High blood pressure ?	□ **Yes** □ **No**
Blood Clots ?	□ **Yes** □ **No**	Pulmonary embolism ?	□ **Yes** □ **No**
Aortic Aneurysm ?	□ **Yes** □ **No**	Angioplasty/stent placement ?	□ **Yes** □ **No**
Heart Attack ?	□ **Yes** □ **No**	Heart attack in the past 12 month ?	□ **Yes** □ **No**
Pacemaker or AICD?	□ **Yes** □ **No**	Have you ever had a stroke ?	□ **Yes** □ **No**
Heart disease or heart problems ?			□ **Yes** □ **No**
Currently taking Coumadin, Aspirin, Plavix, Pradaxa or other anticoagulant/blood thinner?			□ **Yes** □ **No**
Heart Catherization/Stress test ? □ **Yes** □ **No** Date : Normal ? Abnormal ?			
Prior parotidectomy (salivary gland removal)?			□ **Yes** □ **No**
Current/ past smoker?	□ **Yes** □ **No**	History of seizure disorder ?	□ **Yes** □ **No**
Severe dry eyes ?	□ **Yes** □ **No**	Limited neck mobility ?	□ **Yes** □ **No**

If you answered yes to any of the above, please provide details below and indicate the name of treating physician and the last time you were treated. Please list any other special concerns or information about your medical health including any recent illnesses or hospitalizations.

_____

_____

_____

May we contact your physician(s) in order to obtain a medical clearance if necessary ? □ **Yes** □ **No**

Pharmacy name: _____ Tel Number: _____

Family Physician: _____ Tel Number: _____

Cardiologist: _____ Tel Number: _____

Other specialist: _____ Tel Number: _____

Past Surgical History

Medications/Supplements/Vitamins	Dose/Frequency

Allergies to Medications?: _____ _____ _____

I certify that I have listed all of my current medications, allergies, hospitalizations, medical conditions and previous surgeries to the best of my knowledge and ability.

_____ _____

Signature Date