

**GARCIA FACIAL PLASTIC SURGERY INSTITUTE**

**700 3<sup>rd</sup> Street, Suite 102  
Neptune Beach, FL 32266**

**PATIENT DEMOGRAPHIC AND HISTORY QUESTIONNAIRE**

**PATIENT INFORMATION**

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ M.I. \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_

CELL # \_\_\_\_\_ WORK PHONE \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

SSN \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

How did You Hear About Us \_\_\_\_\_

EMERGENCY CONTACT PERSON & TEL. NO. \_\_\_\_\_

**TELL US WHAT YOU ARE CONCERNED WITH (Please Fill Out All Lines)**

Appearance of Your Eyebrows? \_\_\_\_\_ Appearance of Your Upper Eyes? \_\_\_\_\_ Appearance of Your Lower Eyes? \_\_\_\_\_

Appearance of Your Cheeks? \_\_\_\_\_ Appearance of Your Neck? \_\_\_\_\_ Appearance of Your Chin? \_\_\_\_\_ Appearance of Your Lips? \_\_\_\_\_

Appearance of Your Ears? \_\_\_\_\_ Appearance of Your Skin? \_\_\_\_\_ Appearance of Your Nose? \_\_\_\_\_ Function of Your Nose? \_\_\_\_\_

Appearance of the Lines/Folds on your face? \_\_\_\_\_ Appearance of any Scars on Your Face? \_\_\_\_\_

*Are You Concerned with a Lesion on Your Face?* \_\_\_\_\_

*Are there any areas of your body that you would you like to improve or enhance?*

\_\_\_\_ Breasts      \_\_\_\_ Thighs/Legs      \_\_\_\_ Arms      \_\_\_\_ Torso (Belly, Love Handles, Back)

*Are you interested in scheduling a consultation with Dr. James Hardy, our Body Contouring Plastic Surgeon?* \_\_\_\_\_

**SURGERY/MEDICALQUESTIONNAIRE**

Please list all surgeries you have had in the past \_\_\_\_\_

\_\_\_\_\_

Please list all medical problems that you may have \_\_\_\_\_

\_\_\_\_\_

Is there any family history of bleeding disorders or problems with anesthesia \_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS**

What medications do you take? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please List any Drug Allergies \_\_\_\_\_

PRIMARY CARE? Who is your primary doctor or your referring physician? \_\_\_\_\_

**PLEASE TURN OVER**

**MEDICAL, SURGICAL AND SOCIAL HISTORY**

**YES NO**

- Do you suffer from frequent headaches?
- Do you suffer from dizziness?
- Blackout spells?
- Dry eyes?
- Black or bloody stools?
- Weight loss?
- Weight gain?
- Fever blisters?
- Do you bruise easily?
- Do you have abnormal or heaving bleeding from anywhere in your body?
- Anemia or blood problems?
- Do you have weakness in your arms or legs?
- Numbness anywhere?
- Are you allergic to ANYTHING?
- Do you consider yourself healthy?
  
- Have you been hospitalized within 24 months
- Have you had contact with persons with staph infections?

**YES NO**

- Do you have urinary problems?
- Have you been treated for genital blisters or any other genital problems?
- Do you have HIV or AIDS?
- Do you have Hepatitis A, B or C? (Circle which one)
- Do you get irritated easily?
- Have you ever been under the care of a psychiatrist or psychologist?
- Have you ever received alcohol or drug abuse treatment?
- Do you smoke or do you have a history of smoking?
- Do you drink more than 2 drinks per day?
- Do you take or use illicit drugs of any kind?
- Do you have any other medical conditions?
- Have you ever had any kind of problems (nausea, trouble with recovery, etc) with any kind of anesthesia (local, general, twilight)?
- Have you ever had MRSA (staph infections)?
- Have you been on antibiotics within the past 12 months?

Aside from the question “do you consider yourself healthy”, please explain any question answered YES in the space provided below.

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Yes  No  Do you authorize and give consent to have the recommended diagnostic, medical, surgical, photographic and aesthetic services that our physicians or staff deem beneficial to you while under our care?

Yes  No  Have you read the patient’s Bill of Rights?

Please list any other problem areas or concerns that you may have in the space below \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I wish to be contacted in the following manner, please check all that apply:**  home phone  work phone  cell phone  e-mail

Your email will not be shared with any outside parties but may be used to inform you of periodic incentives and promotions.

I have received information regarding the providers of care in this organization.

I have been offered a copy of the Patient’s Bill of Rights and Responsibilities.

I have received information regarding the grievance process.

Signed: \_\_\_\_\_ Today’s Date: \_\_\_\_\_

By signing the above, I affirm that all information I have provided on this questionnaire is truthfully accurate.

Thank you for taking the time to answer these questions. They are very important in our assessment. Please write any additional questions anywhere on this sheet so that they may be addressed at the time of your consultation.

Welcome to Garcia Facial Plastic Surgery Institute.