Patient Demographic and Medical Questionnaire

PATIENT INFORMATION:

Last ________________________________ First ________________________________ M.I. _________
Street Address ____
City ______________________ State ______ Zip ____________ Cell Phone ____________________
Home Phone ________________ Work Phone __________________ Sex_____ Marital Status________
SSN _________________________ Birthdate __________________ Occupation ____________________
Email Address: ____
How did you hear about us? ____
EMERGENCY CONTACT PERSON & PHONE # ____

Height: _________________ Weight: _________________

TELL US WHAT YOU ARE CONCERNED WITH:
Are you pleased with your appearance? (yes or no)

Eyebrows?	Upper Eyes?	Lower Eyes?
Cheeks?	Neck?	Chin?
Lips?	Ears?	Skin?
Nose?	Function of Nose?	Lines/Folds on Face?
Scars on Your Face?	Lesion on Your Face?	Other?

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

SURGERY / MEDICAL QUESTIONAIRE:
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? ____
____

Who is your Primary doctor or your referring physician? ____

MEDICAL, SURGICAL AND SOCIAL HISTORY:

Yes	No		Yes	No	
		Do you suffer from frequent headaches?			Do you have urinary problems?
		Do you suffer from dizziness?			Have you been treated for genital blisters or any other genital problems?
		Blackout spells?			Do you have HIV or AIDS?
		Dry eyes?			Do you have Hepatitis A, B or C? (circle one)
		Black or bloody stools?			Do you get irritated easily?
		Weight loss?			Have you ever been under the care of a psychiatrist or psychologist?
		Weight gain?			Have you ever received alcohol or drug abuse treatment?
		Fever blisters?			Do you smoke or do you have a history of smoking?
		Do you bruise easily?			Do you drink more than 2 drinks per day?
		Do you have abnormal or heaving bleeding from anywhere in your body?			Do you take or use illicit drugs of any kind?
		Anemia or blood problems?			Do you have any other medical conditions?
		Do you have weakness in your arms or legs?			Have you ever had any kind of problems (nausea, trouble with recovery, etc) with any kind of anesthesia (local, general, twilight)?
		Numbness anywhere?			Have you ever had MRSA (staph infections)?
		Are you allergic to ANYTHING?			Have you been on antibiotics within the past 12 months?
		Do you consider yourself healthy?			Have you been on antibiotics within the past 12 months?
		Have you been hospitalized within 24 hours?			Have you had contact with persons with staph infections?

Aside from the question "do you consider yourself healthy" please explain any question answered YES in the space provided below. ____
____

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 or care?
Yes ____ No ____ Have you read the patient's Bill of Rights?

I wish to be contacted in the following manner, please check all that apply:
____ Home Phone ____ Work Phone ____ Cell Phone ____ Email

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: ____ Date: ________________________________

By signing 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! Welcome to Garcia Facial Plastic Surgery Institute.