GARCIA
FACIAL PLASTIC SURGERY

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 # _____
Relation: _____
Race: _____ Ethnicity: _____ Height: _____ Weight: _____
Occupation: _____ Company: _____

TELL US WHAT YOU ARE CONCERNED WITH:

Are you pleased with your appearance? (yes or no, check all that apply)

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:

_____
_____

WHAT PROCEDURES ARE YOU INTERESTED IN? (check all that apply)

Facelift?	Lower Eyelids?	Kybella?	Juvederm Ultra + ?
Necklift?	Lip Advancement?	Belotero?	Voluma?
Cheeklift?	Chin Implant?	Botox?	Radiesse?
Browlift?	Cheek Implant?	Dysport?	Restylane?
Rhinoplasty?	Chemical Peel/Dermabrasion?	Xeomin?	Restylane Silk?
Otoplasty(ears)?	Earlobe Repair?	Juvederm Ultra?	Restylane Lift?
Upper Eyelids?	Contoura (fat transfer)?		

Who is your Primary doctor or your referring physician? _____

PATIENT PAST MEDICAL HISTORY: (check all that apply)

No Pertinent Past History	Hives
Asthma	Kidney Stones
Bleeding Disorder	MRSA/STAPH Infection
Breast Cancer	Skin Cancer
Cancer	Skin Disease
Chest Pain/Tightness	Stroke
Diabetes	Thyroid Disorder
Eczema	Tuberculosis
Heart Disease	Ulcers
Heart Murmur	Urinary Tract Infection
Hepatitis	Xray Therapy
High Blood Pressure	

SURGERY / MEDICAL QUESTIONAIRE (if none, please type none)

Surgery / Hospitalization	**Date**	**Anesthesia Complications**	**Notes**

FAMILY MEDICAL HISTORY: (check all that apply)

	Afflicted Family Member	**Notes**
No Relevant Family History		
Unknown - Adopted		
Autoimmune Disorders		
Bleeding Complications		
Colon Cancer		
Diabetes		
Glaucoma		
High Blood Pressure		
High Cholesterol		
Liver Disease		
Lung Disease		
Malignant Melanoma		
Obesity		
Premature Coronary Heart Disease		
Skin Cancer		
Thyroid Disease		

ALLERGIES (if none, please type none)

Allergy	Reaction	Notes

MEDICATIONS (if none, please type none)

Drug	Dosage	Prescribed By

Smoking Status? _____ How Often? _____

PATIENT SOCIAL HISTORY

Alcohol	Illegal Drugs	STD
Denies alcohol use	Denies using illegal drugs	Denies STD history
Admits alcohol use socially	Admits to using illegal drugs	Admits STD history
Admits alcohol use daily	Admits to history of drug abuse	
Admits to history of alcoholism		

PATIENT ABILITY TO HEAL

	Yes	No
Does your skin appear fragile, burns easily?		
Do you form thick or raised scarring from a cut or burn?		
Do you wax or use depilatories on your face?		
Do you ever get cold sores?		
Do you have problems with excessive scarring or keloids?		

FEMALE QUESTIONS

	Yes	No	N/A
Do you have regular periods?			
Are you going through menopause?			
Are you pregnant or lactating?			
During pregnancy, did you ever get hyperpigmentation or masking?			

MEDICAL HISTORY VERIFICATION

	Patient / Guardian Initials	Date
All information provided above is accurate and complete		
I have read the Patient Bill of Rights		
I have read the HIPAA Form		
I have reviewed the Photography Consent		

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.