

Michael R. Warner, M.D.
Laser and Cosmetic Dermatology
Mohs Micrographic Surgery

THE
**COSMETIC &
SKIN SURGERY**
C E N T E R


Wyatt C. To, M.D.
Facial Plastic and Reconstructive Surgery

THE COSMETIC AND SKIN SURGERY CENTER
PATIENT DEMOGRAPHIC SHEET

Name: _____ Date: _____

Occupation: _____

Gender: _____ Marital Status: _____

Date of Birth: _____ SSN: _____

HOME

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

Emergency contact : _____

How would you prefer to be contacted? _____

Please list your email address below giving us permission to send you promotional emails
notifying you of upcoming events and special discounts.

Email Address: _____

WORK / SCHOOL

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

May we contact you at work? Yes No

SPOUSE

Name: _____

Occupation: _____

Phone: _____ Cell: _____

How did you hear about The Cosmetic and Skin Surgery Center?

May we send a thank you note to the person who referred you (if applicable)? Yes No

PRACTICE FINANCIAL POLICY

Unless other arrangements have been made in advance, full payment is due at the time of service.

Patient Signature

Date

THE COSMETIC AND SKIN SURGERY CENTER
SURGERY INFORMATION SHEET

Name: _____ Date: _____

What area(s) are you interested in having improved? Please describe past treatments to this area.

What do you use on your skin in the morning? _____

What do you use on your skin in the evening? _____

Have you ever had or used the following

Permanent makeup Yes No

Injected fillers (Restalyne, collagen) Yes No

Botox Yes No

Accutane Yes No

ALLERGIES

Any drug allergies (including local anesthetics and codeine) Yes No

If yes, please list drug and reaction type.

Tape allergy Yes No

MEDICATION

Please list any medications you are currently taking and dosage, including all medications taken within the past month, vitamins and herbal remedies.

Are you taking aspirin or medication containing aspirin? Yes No

Are you taking other NSAIDs (Advil, Alleve etc.) Yes No

Have you taken any steroid preparations in the past year? Yes No

Do you take prophylactic antibiotics prior to procedures? Yes No

If yes, please state reason. _____

MEDICAL EVALUATION

How is your general health? _____

Are you presently being treated for any medical conditions? _____

When was your last physical examination? _____

Do you have any of the following?

Visual loss (one or both eyes) Yes No

“Dry” eyes Yes No

Itching or irritation of eyes Yes No

Blurred or double vision Yes No

Crossed or lazy eyes Yes No

Cornea problems Yes No

Thyroid eye disease Yes No

Wear glasses or contacts Yes No

Previous eye or eyelid surgery (if yes what type) Yes No

Difficulty breathing through nose Yes No

Previous injury to nose Yes No

Nasal allergies Yes No

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Nose bleeds Yes No
Sinus conditions Yes No
Previous nasal or sinus surgery (if yes what type) Yes No

Previous face or neck surgery (if yes what type) Yes No

Radiation to the face or neck Yes No
Facial paralysis or weakness Yes No
Facial implants Yes No
Coronary or heart attack Yes No
Congenital heart disease Yes No
Heart murmur Yes No
Palpitations, irregular heartbeat or pacemaker/defibrillator Yes No
High blood pressure Yes No
Stroke Yes No
Shortness of breath Yes No
Chronic lung disease Yes No
Chronic cough Yes No
Asthma Yes No
Have you received psychiatric treatment? Yes No
If yes, were you hospitalized? Yes No
Has there been any recent crisis in your life? Yes No
Have you ever been treated for drug or alcohol dependency? Yes No
Liver disorders including hepatitis or cirrhosis Yes No
Kidney or bladder disorders or chronic infections Yes No
Spinal or back disorders Yes No
Previous blood clots or thrombophlebitis Yes No
Any bleeding disorders in self or family Yes No
Blood transfusions Yes No
Do you feel that for any reason you may be at risk for AIDS? Yes No
Diabetes Yes No
Autoimmune diseases (e.g. lupus, rheumatoid arthritis) Yes No
Any unusual scarring or keloid formation Yes No
If applicable, are you pregnant or trying to get pregnant? Yes No
Skin cancer Yes No
Do you smoke? (If yes please list packs per day and years) Yes No

Do you drink more than two drinks per day? Yes No

The information above is true and accurate to the best of my knowledge.

Patient Signature

Please list below any questions you would like to have specifically answered during your consultation.
