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

THE
COSMETIC & SKIN SURGERY
CENTER

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

PATIENT DEMOGRAPHIC SHEET

Name: ______________________________ Date: __________

Occupation: ______________________________

Gender: ______________ Marital Status: ______________

Date of Birth: ______________ SSN: ______________

HOME

Street: ______________________________

City: ______________ State: ______ Zip: __________

Phone: ______________ Cell: ______________

Emergency contact : ______________________________

E-Mail Address______________________________

WORK / SCHOOL

Street: ______________________________

City: ______________ State: ______ Zip: __________

Phone: ______________ Fax: ______________

Please list family members or other persons, whom we may inform about your treatment, scheduling, and billing information:

Name	Relationship	Date of Birth	Phone #

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

I authorize Michael R. Warner, M.D. & Wyatt C. To, M.D. to leave messages as it pertains to my health or appointments on:

☐ My home answering machine ☐ My work answering machine

☐ My cell phone ☐ With my family members or others residing in my household

PRACTICE FINANCIAL POLICY

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

Signature______________________________ Date______________

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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 (Restylane, 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, Aleve 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

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/defibrilator	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Seizure Disorders	☐ 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
Cold Sores	☐ 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

Have you had a communicable disease in the past six months? ☐Y ☐N

If yes, please explain: ____
____

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

Primary Care Physician:_________________________ Phone Number:____________________

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