

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 _____

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 (Restylane, collagen) Yes No

Botox Yes No

Accutane Yes No

MEDICATION & ALLERGIES

(Please use the Medication Reconciliation Record)

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