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: _____

E-Mail Address: _____

Emergency Contact: _____

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.

Cosmetic consultation fees are nonrefundable. They may be applied to in office cosmetic treatments within (6) months of consultation. *Fees may not be applied to product purchases.

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 (e.g. Juvéderm, Restylane, collagen)	☐ Yes	☐ No
Neurotoxins (e.g. Botox, Dysport, Xeomin)	☐ 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 (e.g. 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

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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
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 use an electronic cigarette or vape?	☐ Yes	☐ No
Do you use nicotine in any form? (e.g. patches, gum, etc.)	☐ 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.

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DOB _____ Patient Name _____

Please list ALL known prescriptions, over- the-counter, herbals, and vitamin/mineral/dietary (nutritional) supplements.

Name (Reported by Patient)	**Dosage**	**Frequency**	**Route** (Oral, Sub-Q)

Are you ALLERGIC to any drugs or materials? ❒ YES ❒ NO If yes, list:

Allergy or Sensitivity (Reported by patient)	**Reaction**

LATEX ALLERGY ❒ YES ❒ NO **Patient Initials** _____ **Staff Initials** _____

_____ _____ _____
(Physicians Initials) (Patient Signature) (Date)

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My signature confirms that I have reviewed the original list of prescriptions/medications. I have marked and dated all changes, and to the best of my knowledge, is up-to-date and inclusive.

Date	Patient/Guardian Signature	Physicians Initials