OREGON HEALTH & SCIENCE UNIVERSITY

Facial Plastic & Reconstructive Surgery
New Patient Questionnaire

- Please fill out all of the following questions to the best of your ability.
- Please write "N/A" if the question is NOT applicable to you.

Patient Name: _____ **Age**: _____ **Sex:** M / F (circle one)
At what phone number would you like to be contacted if needed? (_____)_____-_____
EMAIL: _____
What is your occupation? _____ Do you live alone? **YES / NO** (circle one)
How did you hear about us? _____ Who is your Primary Physician? _____

REASON FOR YOUR VISIT:
Please explain the reason for your appointment today:

_____
_____
_____

MEDICAL HISTORY:
Please check all that apply; List any other medical conditions that are not listed below:

O Asthma / Lung Disease
O Arthritis
O Anemia
O Bleeding Disorder
O Diabetes
O Dizziness
O Cancer
O Cough
O Chronic Pain
O Depression
O Heart Disease
O High Blood Pressure
O Heartburn / Reflux
O Headaches
O High Cholesterol
O Kidney Disease
O Liver Disease (Hepatitis)
O Menopause
O Nose Bleeds
O Seizures
O Stroke
O Tuberculosis (TB)

List any other medical conditions that you have or have had:
_____
_____

List Family History:
_____
_____

Is there anything else you would like your Doctor to know?

_____
_____
_____

SURGICAL HISTORY:
Please list and describe any past surgeries**:**

_____ **Date** _____
_____ **Date** _____
_____ **Date** _____
_____ **Date** _____

← Please turn page over to complete form →

MEDICATIONS:
Please list all medications that you currently take. ***Please* INCLUDE *vitamins & other Supplements:***

Name of Medication Dosage Times per day Purpose for Medication

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Which Pharmacy do you use? _____ City:_____

ALLERGIES:
Please list any allergies you may have to medications/drugs or foods:

_____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____

Have you ever had a reaction to anesthesia? If so, explain: _____
_____

Do you bleed or bruise easily? **YES / NO** (circle one)
Do you form large or thickened scars? **YES / NO** (circle one)

Do you smoke? **YES / NO** (circle one) If so, _____# of years #_____ packs/day
Do you drink alcohol or wine? **YES / NO** (circle one) If so, how often? _____

FOR PATIENTS CONSIDERING COSMETIC SURGERY, PLEASE ALSO COMPLETE THE FOLLOWING:

I am interested in information about the following: (check all that apply)

O Facial Skin Rejuvenation
O Facial Wrinkle Correction
O Botox
O Facial Fillers
O Facial Implants
O Rhinoplasty / Nasal Surgery
O Face / Neck Lift
O Forehead / Brow Lift
O Eyelid Rejuvenation
O Scar Revision

Thank you for visiting our office. We look forward to providing you with excellent service.