PATIENT INFORMATION AND MEDICAL HISTORY

Name: _____ Date: _____ Age: _____

Address: _____

(Street) (City) (State) (Zip Code)

Phone: Home _____ Cell _____ Work_____

Date of Birth: _____ Marital Status: _____

Occupation: _____ Employer: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone: Home _____ Cell _____ Work_____

Health History

Medications (prescription and over the counter; vitamins, herbal medications):

_____

_____

_____

Allergies: _____

Are you allergic to cow's milk: ☐ Y ☐ N

Facial Surgeries/Dates:

_____

_____

Do you have a history of one of the following?

__ Heart disease __ Mental illness __ Neuro-muscular disease

__ Excessive bleeding __ Auto-immune disorders __ Diabetes

__ High blood pressure __ Liver disease __ Cold sores/fever blisters

__ Kidney disease

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Date of last NSAID taken: _____

(e.g. Aspirin, Advil/ibuprofen, Aleve/naproxen, Indocin/indomethacin, Voltaren/diclofenac, Celebrex/celecoxib, Lodine/etodolac)

Are you pregnant? ☐ Y ☐ N

Are you nursing? ☐ Y ☐ N

Do You Smoke? ☐ Y ☐ N

Do you drink alcohol? ☐ Y ☐ N

Amount per day: _____

Amount per day: _____

Why are you here today? _____

What are your anesthetic goals? _____

Have you ever received botox, or a botox equivalent? ☐ Y ☐ N Name: _____

Have you ever received HA fillers or the equivalent? ☐ Y ☐ N Name: _____

_____ _____

Patient Signature Date

Name of supervising MD (if applicable) ___ Wayne Olan MD_____

Name of medical professional providing services _____Ashley Perkins PA-C_____