BLACKLEDGE FACE CENTER
Consultation and Medical History

Name: ______________________________________ Age: ________________________

Occupation: __________________________________ Date: ________________________

What area(s) of the face are you interested in having improved?

How is your general health?

Are you presently being treated for any medical conditions?

EYE

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	_____Ye s	_____No
Previous eye or eyelid surgery	_____Yes	_____No

CARDIOVASCULAR

Hypertension	_____Yes	_____No
Coronary or heart attack	_____Yes	_____No
Congenital heart disease	_____Yes	_____No
Heart murmur	_____Yes	_____No
Stroke	_____Yes	_____No

PSYCHIATRIC

Previous drug/alcohol dependency	_____Yes	_____No
Previous psychiatric treatment	_____Yes	_____No

ALLERGIES

Drug Allergies	_____Yes	_____No

If yes, list drug and reaction type

Latex allergy	_____Yes	_____No
Tape allergy	_____Yes	_____No

MEDICATIONS

Are you currently on aspirin	_____Yes	_____No

List medications you are presently taking (including vitamin and herbals) and dosage (within the last month).

NOSE

Difficulty breathing through nose	_____Yes	_____No
Previous injury to nose	_____Yes	_____No
Nose bleeds	_____Yes	_____No
Nasal allergies	_____Yes	_____No
Previous nasal or sinus surgery	_____Yes	_____No
Previous face or neck surgery	_____Yes	_____No
Irradiation of face or neck	_____Yes	_____No
Facial paralysis or weakness	_____Yes	_____No
Facial skin problems	_____Yes	_____No

CHEST

Shortness of breath	_____Yes	_____No
Chronic lung disease	_____Yes	_____No
Chronic cough	_____Yes	_____No
Asthma	_____Yes	_____No
Do you smoke	_____Yes	_____No

OTHER

Liver disorder	_____Yes	_____No
Kidney or bladder disorders	_____Yes	_____No
Spinal or back disorders	_____Yes	_____No
History of blood clots	_____Yes	_____No
Bleeding disorders	_____Yes	_____No
Blood transfusion	_____Yes	_____No
Autoimmune disease	_____Yes	_____No
Unusual scarring/keloid formation	_____Yes	_____No
If applicable, are you pregnant	_____Yes	_____No
Date of last menstrual period	________________________	
Diabetes	_____Yes	_____No
History of seizures	_____Yes	_____No
History of fever blisters	_____Yes	_____No

SOCIAL

Drink more than two drinks per day	_____Yes	_____No

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SIGNATURE