BLACKLEDGE FACE CENTER

NEW/UPDATED PATIENT INFORMATION

NAME_____SS#_____

ADDRESS_____

CITY/STATE_____ZIP_____

HOME PHONE_____CELL PHONE_____

WORK PHONE_____ EMAIL_____

EMPLOYER_____OCCUPATION_____

BIRTH DATE_____ ☐ single ☐ married ☐ widow(er) GENDER: ☐ male ☐ female

SPOUSE'S NAME_____ SPOUSE'S EMPLOYER_____

REFERRAL SOURCE_____

PHARMACY_____ PHARMACY PHONE_____

MINOR OR STUDENT INFORMATION

MOTHER'S NAME_____BIRTH DATE_____PHONE_____

ADDRESS_____

CITY/STATE_____ZIP_____

FATHER'S NAME_____BIRTH DATE_____PHONE_____

ADDRESS_____

CITY/STATE_____ZIP_____

EMERGENCY CONTACT

NAME_____RELATIONSHIP TO PATIENT_____

HOME PHONE_____ WORK PHONE_____

SURGICAL HISTORY LIST ANY PROCEDURES YOU HAVE HAD AND APPROXIMATE DATES

_____

_____

MEDICATION ALLERGIES LIST ANY MEDICATION ALLERGIES OR OTHER ALLERGIES

_____

_____

MEDICATIONS LIST ANY MEDICATIONS TAKEN ROUTINELY

_____

_____

Occassionaly, our staff may contact you to remind you of upcoming appointments or check on your progress. Please see below.

☐ I give Blacklege Face Center permission to call or leave messages for me at the above listed phone numbers.

☐ I **do not** give Blackledge Face Center permission to call me.

☐ I give Blacklege Face Center permission to email me promotional materials.

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CONSULTATION & MEDICAL HISTORY

BLACKLEDGE FACE CENTER

NAME_____AGE_____

OCCUPATION_____DATE_____

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

_____

What services are you interested in?

☐ Injections ☐ Laser (hair, veins, pigmentation) ☐ Skincare ☐ Cellulite

☐ Surgery ☐ BodySculpting ☐ Skincare products

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	☐ yes	☐ 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

Latex allergy	☐ yes	☐ no
Tape allergy	☐ yes	☐ no
Drug allergies	☐ yes	☐ no

If yes, list drug & reaction type:

_____

_____

_____

_____

MEDICATIONS

Are you currently on aspirin?	☐ yes	☐ no

NOSE

Difficulty breath 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 distorders	☐ yes	☐ no
History of blood clots	☐ yes	☐ no
Bleeding disorders	☐ yes	☐ no
Blood transfusion	☐ yes	☐ no
Autoimmune disease	☐ yes	☐ no
Ususual 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 2 drinks a day	☐ yes	☐ no

List current medications & dosage within the last month (including vitamin & herbals):_____

_____

_____

_____

SIGNATURE:_____