AMERICAN ACADEMY OF FACIAL PLASTIC
& RECONSTRUCTIVE SURGERY

AMERICAN ACADEMY OF
COSMETIC SURGERY

BOARD CERTIFIED

AMERICAN BOARD OF FACIAL PLASTIC
& RECONSTRUCTIVE SURGERY

# CONSULTATION & MEDICAL QUESTIONNAIRE

NAME_________________________ NICKNAME_________________________ DATE_______________

DATE OF BIRTH_________________________ SSN#_________________________

ADDRESS_________________________ CITY_________________________

STATE_________________________ ZIP_______________ IS IT OK TO MAIL? YES NO

PHONE # (WORK)_________________________ (HOME)_________________________ (CELL)_________________________

Which phone number would you prefer we use when contacting you? Work_________ Home_________ Cell_________

If you checked a home phone #, can we leave a detailed message? YES NO

E-MAIL ADDRESS_________________________

EMPLOYER_________________________ OCCUPATION_________________________

Name/Phone of emergency contact_________________________ Relationship_______________

How did you hear about us? _________________________

Bellsouth Yellow Pages/Nashville_______Brentwood/Franklin________Murfreesboro________Columbia/Springhill_____

Newspaper_____________ Other Publication______________Internet/Website____________Word of Mouth_____________

Attended Program/Seminar____________________Drive By_______________________Your Doctor___________________

Other (please specify)_________________________Who can we thank for referring you?_________________________

How long have you considered pursuing cosmetic medical or surgical services?_________________________

Has anyone else in your family or a close friend had cosmetic or reconstructive surgery? YES NO

What was done?_________________________

_________________________

## MEDICAL HISTORY

Family Doctor/Primary Physician _________________________ Phone #_________________________

When was your last physical examination?_________________________

Would you object if we contact your doctor concerning your care at our office? YES NO

When was your last eye examination?_________________________

List all surgeries since childhood:

Date: ____________ ______________________________ Date: ____________ ______________________________

Date: ____________ ______________________________ Date: ____________ ______________________________

List all prescription medications:

Medication:_________________________________ Dose:_______________________ How many times a day?________

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Medication:_________________________________ Dose:_______________________ How many times a day?________

Medication:_________________________________ Dose:_______________________ How many times a day?________

Medication:_________________________________ Dose:_______________________ How many times a day?________

Allergies (Please list name of medication and what happened when you took it. Include local anesthetics and codeine)

____________________________________________________________________________________________________

____________________________________________________________________________________________________

| | | |
|---|---|---|
| Do you take aspirin or any medication containing aspirin? | YES | NO |
| Have you taken any steroid preparations in the past year? | YES | NO |
| Do you smoke? | YES | NO |
| Do you usually drink two or more alcoholic drinks a day? | YES | NO |
| Do wear glasses or contacts? | YES | NO |

**PLEASE COMPLETE ALL OF THE FOLLOWING QUESTIONS.**

**Have you or any family member ever had trouble with:**

| **EYES** | **Myself** | | **Relative** | | **Relationship to you** |
|---|---|---|---|---|---|
| Vision loss (one or both eyes) | YES | NO | YES | NO | ________________ |
| "Dry" eyes | YES | NO | YES | NO | ________________ |
| Itching or irritation of the eyes | YES | NO | YES | NO | ________________ |
| Blurred or double vision | YES | NO | YES | NO | ________________ |
| Crossed or lazy eyes | YES | NO | YES | NO | ________________ |
| Cornea problems | YES | NO | YES | NO | ________________ |
| Thyroid eye disease | YES | NO | YES | NO | ________________ |

| NOSE | Myself | | Relative | | Relationship to you |
|---|---|---|---|---|---|
| Difficulty breathing through nose | YES | NO | YES | NO | ________ |
| Previous injury to nose | YES | NO | YES | NO | ________ |
| Nasal allergies | YES | NO | YES | NO | ________ |
| Frequent nosebleeds | YES | NO | YES | NO | ________ |
| Sinus problems | YES | NO | YES | NO | ________ |
| Nasal polyps | YES | NO | YES | NO | ________ |

| FACE/HEAD | Myself | | Relative | | Relationship to you |
|---|---|---|---|---|---|
| Irritation of the face or neck | YES | NO | YES | NO | ________ |
| History of radiation for acne treatment | YES | NO | YES | NO | ________ |
| Acne | YES | NO | YES | NO | ________ |
| Vitiligo (Loss of color to patches of skin) | YES | NO | YES | NO | ________ |
| Keloid formation | YES | NO | YES | NO | ________ |

| CARDIOVASCULAR | Myself | | Relative | | Relationship to you |
|---|---|---|---|---|---|
| Angina, or history of chest pain | YES | NO | YES | NO | ________ |
| Heart murmur | YES | NO | YES | NO | ________ |
| Mitral valve prolapse | YES | NO | YES | NO | ________ |
| History of heart attack | YES | NO | YES | NO | ________ |
| Congenital heart disease | YES | NO | YES | NO | ________ |
| Palpitations or irregular heartbeat | YES | NO | YES | NO | ________ |
| Stroke | YES | NO | YES | NO | ________ |
| High blood pressure | YES | NO | YES | NO | ________ |

| CHEST | Myself | | Relative | | Relationship to you |
|---|---|---|---|---|---|
| Shortness of breath | YES | NO | YES | NO | ________ |
| Asthma | YES | NO | YES | NO | ________ |
| Chronic lung disease | YES | NO | YES | NO | ________ |

| PSYCHIATRIC | Myself | | Relative | | Relationship to you |
|---|---|---|---|---|---|
| Have you received psychiatric treatment? | YES | NO | YES | NO | ________ |
| If so, were you hospitalized? | YES | NO | YES | NO | ________ |
| Has there been any recent crisis in your life? | YES | NO | YES | NO | ________ |
| Have you ever been treated for drug or alcohol dependency? | YES | NO | YES | NO | ________ |

| OTHER | Myself | | Relative | | Relationship to you |
|---|---|---|---|---|---|
| Ulcers or stomach problems | YES | NO | YES | NO | ______ |
| Gallbladder trouble | YES | NO | YES | NO | ______ |
| Seizures or convulsions | YES | NO | YES | NO | ______ |
| Kidney problems or urinary tract infections | YES | NO | YES | NO | ______ |
| Liver disorder; hepatitis or cirrhosis | YES | NO | YES | NO | ______ |
| Spinal or back disorders | YES | NO | YES | NO | ______ |
| Previous blood clots or thrombophlebitis | YES | NO | YES | NO | ______ |
| Free bleeding or bleeding disorders | YES | NO | YES | NO | ______ |
| History of blood transfusions | YES | NO | YES | NO | ______ |
| Diabetes | YES | NO | YES | NO | ______ |
| Autoimmune disease (lupus, rheumatoid arthritis, etc.) | YES | NO | YES | NO | ______ |
| If applicable, are you pregnant? | YES | NO | YES | NO | ______ |

Have you ever taken Accutane (for acne)? YES NO

Do you have a history (EVER) of cold sores or fever blisters? YES NO

Have you ever had a positive blood test for HIV? YES NO MRSA? YES NO TB? YES NO

Please list any additional medical concerns: ______________________________

______________________________

______________________________

Please list any questions you would like addressed by Dr. Clymer or the staff: ______________________________

______________________________

______________________________

______________________________

Signature