Facial Cosmetic Surgery
Patient Information Worksheet

Cosmetic Services, Kaiser – Santa Rosa
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(707) 566-5288

Date _____/_____/_____
Name _____**Medical Record #**_____
Age _____
Height _____ft _____in
Current Weight_____lbs. **Heaviest** _____lbs. **Lightest** _____lbs. **Ideal**_____lbs

Past Medical History:

Skin
Have you ever seen a dermatologist for your skin? Yes / No
What topical medications do you use now or have ever used? (e.g., *Retin-A*®) What, When, How, Why and How Long?

_____
Is your skin ever shiny a few hours after cleansing? Yes / No
Does your skin ever flake or feel dry? Yes / No
Describe you pigmentation: ☐ Even ☐ Uneven ☐ Birthmark ☐ Pregnancy mask
Do you sun bathe? Yes / No Do you use a tanning salon? Yes / No
When exposed to the sun, do you?
☐ Always burn ☐ Usually burn ☐ Burn then tan ☐ Usually tan ☐ Always tan
Do you have broken capillaries? Where? _____
Do you have? ☐ Deep wrinkles ☐ Crow's feet ☐ Fine Lines
Do you use wax or depilatories on your face? Yes / No
Do you have permanent make-up? Yes / No
Have you ever had any kind of hair removal? Yes / No
Do you form keloids or severe scars Yes / No
Where_____

General Medical
Please list **ALL** medical problems:
_____
_____
Please list **ALL** medications. (List Medication, Dose, & Frequency):
_____
_____
_____
_____

Do you take or have you ever taken in the last month any vitamins, homeopathic medicines, herbs or herbal medicines, botanicals, etc., including echinacea, ephedra (mahuang), garlic, ginko, ginseng, kava, St. John's Wort, or valerian? *(All herbal medicines must be stopped at least 2 weeks before the date of surgery.)* ☐ No If yes, please list.

_____
Have you ever taken cortisone or steroids? Yes / No What, When, How, Why and How Long?
_____
Have you ever taken any type of hormones, including birth control? What, When, Why and How Long?
_____
_____

Please **ALL** list previous surgeries (please include date and surgeon)

_____
_____
_____
_____

Have you ever taken any type of radiation therapy? Yes / No
What_____ When_____
Why_____

Habits

Tobacco use Yes / No Type_____ Amount & Duration _____Quit when?
Alcohol use Yes / No Type_____ Amount & Duration _____
Drug use Yes / No Type_____ Amount & Duration _____

Allergies	**Drug/Food/Allergen**	**Type of Reaction**
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Have you ever had:

- ❑ Injuries Of Your Face Or Neck
- ❑ Infections Of Your Face Or Neck
- ❑ Skin Cancers Of Your Face Or Neck
- ❑ Surgery Of Your Face Or Neck
- ❑ Significant Acne
- ❑ Facial Nerve Disease
- ❑ Facial Paralysis
- ❑ Cold Sores, Shingles or Herpes
- ❑ Chemical Peels
- ❑ Laser Resurfacing
- ❑ Dermabrasion
- ❑ Dry Eyes
- ❑ Visual Impairment
- ❑ Significant sun damage to your skin
- ❑ Keloids Or Severe Scars
- ❑ **Have you ever taken Acutane®?**
- ❑ When? _____

Concerns:

What are your concerns today?

_____
_____
_____

Specifically, what do you wish to accomplish at his visit?

_____
_____

We appreciate your visit and we respect your privacy. Who may we thank for referring you? _____

_____
_____

May we contact this person to thank them? Yes / No

At what number(s) may we

- ☐ Call you?
- ☐ Leave a message with a person and tell them we called?
- ☐ Leave a message on an answering machine?
