THE GEORGIA CENTER

FACIAL PLASTIC SURGERY AND LASER AESTHETICS

613 PONDER PLACE
EVANS, GA 30809
(706) 210-2625

Name _____ Date_____
Sex _____ DOB _____
Address_____
City:_____ State_____ Zip_____
Home#_____Work#_____Cell# _____
Which phone number(s) may we use to leave messages? _____
E-mail address_____
Occupation_____ Employer _____
Emergency Contact _____ Phone # _____
How did you hear about our practice?_____
May we thank them for the referral? _____

Which services are you interested in? (Please check all that apply.)

____ **Face/Necklift, Midface Lift**
____ **Restlyane/Radiesse/Botox**
____ **MicroLaser Peel**
____ **Rhinoplasty**
____ **Dimple Creation**
____ **Scar Revision**
____ **Browlift/Eyelid Surgery**
____ **Implants (Mid-face, Chin, Lip)**
____ **Laser Skin Resurfacing**
____ **Laser Hair Removal**
____ **Lip Augmentation**
____ **Other**

Medications- Please list all medications that you are currently taking. (Include diet pills, herbal preparations, over-the counter medications and vitamins)

Name of Drug	Strength/Dosage	Condition Treated
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies-Please list any allergies to medications, tapes, or antiseptic cleansers.
_____
_____

Name and city of your personal physician _____

Medical Questionnaire *(Please indicate with an "X" all that apply)*

Have you ever had any heart problems?

____High blood pressure ____Chest Pain
____Low blood pressure ____Irregular heart beat
____Heart attack ____Shortness of breath
____Heart murmur

Have you ever had any lung problems?

____Bronchitis ____Shortness of breath
____Pneumonia ____Tuberculosis
____Asthma

Have you ever had any gastrointestinal problems?

____Ulcers ____Colitis
____Gastritis ____Diverticulitis

Have you ever had any musculoskeletal/neurological problems?

____Convulsions ____Epilepsy
____Headaches ____Arthritis

Have you ever had any eye, ear, nose, or throat problems?

____Dry eyes ____Blurred vision
____Glaucoma ____Corrective lenses
____Ear disease ____Nosebleeds
____Difficulty breathing ____Nasal allergies
____Sinus disease

Have you ever had any of the following medical problems?

____Anemia ____Bleeding disorders
____Blood transfusions ____AIDS virus exposure
____Autoimmune disease ____Diabetes
____Thyroid disease ____Hepatitis

Are you currently using Retin-A, Renova, or Differin? ____ Yes ____ No
If so, how long?____ less than 3 mos.____3 mos.-1 year____1 year

Are you currently using the drug Accutane? ____ Yes ____No ____Taken in past

Have you ever had any of the following? (circle)
Botox Microdermabrasion Restylane Radiesse Fat transfer

Have you ever had laser resurfacing? ____ Yes ____ No

Have you had any cosmetic peels? ____ Yes ____No
If so, ____ Spa facial ____ Glycolic/Salicylic/Lactic Acid ____ TCA/Blue Peel

Have you ever been treated for any psychiatric/emotional problems?

____Depression ____Anxiety
Other_____

Medical Questionnaire (con't)

Do you smoke?_____ If yes, how much?_____

Do you drink alcoholic beverages?_____ If yes, how often? Socially Daily

Do you take any recreational drugs?_____ If yes, please specify._____

Medical History

Are you presently under the care of a physician for any medical condition? ___
If yes, please explain._____

Are you pregnant? ____ Planning ____ Yes ____ No
Breast feeding? ____ Yes ____ No

Surgical History- *Please list all previous surgeries, and dates (including cosmetic).*

_____ _____
_____ _____
_____ _____

Hospitalizations- *Please list reason and dates.*

_____
_____
_____

Family History-*Please indicate if any immediate family member has ever had any of the following:*

____Heart disease
____Anesthetic complications
____Bleeding disorder
____Autoimmune disorders
____Other

Patient Signature _____*Date*_____

Physician Signature _____*Date*_____