The Center for Facial Restoration

Richard E. Davis, MD, FACS

Cosmetic and Functional Nasal Surgery · Revision Rhinoplasty · Cosmetic Surgery of the Face

NEW PATIENT QUESTIONNAIRE

Today's Date: _____ Medical Record #: _____

Last Name: _____ First Name: _____ MI: _____

Cell #: _____ Home #: _____ Work #: _____

Age: _____ Gender: _____ Occupation: _____

Reason(s) for Visit: _____

How did you find us? _____ Referred By: _____

Do you currently smoke? ..... Yes / No

If yes, how many packs per day and for how many years? _____

If no, have you ever regularly smoked in the past? ..... Yes / No

If you smoked in the past, how long ago did you quit? _____

Do you consume alcohol? ..... Yes / No

If yes, how often do you drink alcohol? _____

Do you use illicit drugs (e.g. cocaine, marijuana, etc.)? ..... Yes / No

If yes, which drugs and how often? _____

List all prescription drugs you are currently taking (including dosage/intervals):

List all over the counter drugs or herbal supplements you are currently taking, especially those containing aspirin, NSAIDS (such as Advil, Motrin, Nuprin, Aleve and Naprosyn), herbs (such as ginkgo biloba, St. John's wort and kava) and nutritional supplements (such as vitamin E, garlic and omega 3 fish oil):

1951 SW 172 Avenue Suite 205 Miramar, Florida 33029
Office: (954) 442-5191 Fax: (786) 228-2853 Email: info@davisrhinoplasty.com
Website: www.davisrhinoplasty.com

Do you now have, or have you ever had, a history of:

1. Abnormal bleeding or hereditary bleeding disorder? ..... Yes / No
2. Anesthetic complications? ..... Yes / No
3. Diabetes? ..... Yes / No
4. Heart disease (heart attack, chest pain, irregular heartbeat, congestive failure)? ..... Yes / No
5. Lung disease (asthma, emphysema, pneumonia, shortness of breath)? ..... Yes / No
6. Wound healing complications? ..... Yes / No
7. Keloids or hypertrophic scarring? ..... Yes / No
8. Heart murmur requiring preventative antibiotics? ..... Yes / No
9. Radiation treatments? ..... Yes / No
10. Tuberculosis? ..... Yes / No
11. Hepatitis or liver disease? ..... Yes / No
12. Gastric or peptic ulcers? ..... Yes / No
13. Stroke? ..... Yes / No
14. Cancer? ..... Yes / No
15. Kidney disease? ..... Yes / No
16. Psychiatric illness? ..... Yes / No
17. Implants or artificial joints? ..... Yes / No
18. Eye disease (glaucoma, retinal detachment, blindness, cataracts, etc.)? ..... Yes / No
19. High blood pressure? ..... Yes / No
20. Inflammatory or autoimmune disease (Lupus, Wegener's, Sarcoid, MS)? ..... Yes / No
21. HIV or AIDS? ..... Yes / No
22. Family history of abnormal bleeding or malignant hyperthermia? ..... Yes / No
23. Other medical problems? ..... Yes / No

If you answered yes to any of the above, please provide details below (refer to number above):

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List all allergies to medications and materials (such as latex, tape or dyes):

Please list all previous surgeries, including approximate dates:

Please list any complications or problems you experienced during or following the above procedures:

_____ _____
Patient or Patient Representative: Print Name Date

_____
Patient or Patient Representative: Sign Name

Medical Record #: _____

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