BILTMORE plastic surgery

Patient Information

Today's Date:____________

Name:____**Birthday:**_____/_____/_______ **Age:** _______

Height ______________ **Weight:** ___________ **Sex:** ☐Female ☐Male

Address:____

City:____**State**_____**Zip:**_________________

Telephone: Home_______________**Work**__________________________**Cell**_____________________

Email Address: ____

Marital Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient Employed by: ____________________ Occupation: ___________________________

Spouse Name: ___________________________Occupation: ___________________________

PERSONAL PHYSICIAN

Name: _______________________Phone: __________________Address:_______________________

EMERGENCY CONTACT

Name:________________________Phone:_____________________Relationship_________________

MEDICAL HISTORY (Please circle applicable choice)

Heart Disease Asthma Cancer High/Low Blood Pressure Epilepsy

Diabetes Allergies HIV/AIDS Stroke Hepatitis

Other:____

____

MEDICATIONS THAT CAUSE BLEEDING

Do you regularly take any of the following: (Please circle applicable choice)

Aspirin or aspirin-containing medications
Ibuprofen (Motrin, Advil & Nuprin)
Aleve
Vitamin E Anti-inflammatories or muscle relaxants

List ALL drugs or medications currently used:______________________________________

____

____

Prior surgeries, including facial and neck:____

____

____

Allergies to medications or complications from anesthesia:___________________________

____

____

Do you smoke currently?___________ How much per day?__________________________________

I have read and understand the Privacy and Confidentiality Notice and all questions have been answered to my satisfaction. I understand I may have a copy of the Privacy and Confidentiality Notice if I wish.

Patient Signature: ____

Print Name: ____

Date: ____