Palm Beach Facial Plastic Surgery
4280 Professional Center Drive, Suite 310
Palm Beach Gardens, FL 33410
(561) 659-9766
www.PalmBeachFacialPlastic.com

MEDICAL INFORMATION

Name: _____ Date: _____ Age: _____

What area(s) of the face are you interested in having improved? _____
_____
_____

MEDICAL EVALUATION

Height _____ Weight _____

How is your general health?
_____

Are you presently being treated for any medical condition?
_____
_____

When was your last physical examination? _____

EYE

Visual loss…….....	□ Yes	□ No
"Dry" eyes…….....	□ Yes	□ No
Itching or irritation of the eyes…….……....	□ Yes	□ No
Blurred or double vision…….……....	□ Yes	□ No
Crossed or lazy eyes…….....	□ Yes	□ No
Cornea problems…….……....	□ Yes	□ No
Thyroid eye disease…….....	□ Yes	□ No
Wear glasses or contacts…….……....	□ Yes	□ No
Glaucoma……..	□ Yes	□ No
Previous eye or eyelid surgery (if yes, what type)	□ Yes	□ No

_____
_____

NOSE

Difficulty breathing through nose…….……....	□ Yes	□ No
Previous injury to nose……..	□ Yes	□ No
Nasal allergies	□ Yes	□ No
Nose bleeds……..	□ Yes	□ No
Sinus conditions……..	□ Yes	□ No
Previous nasal or sinus surgery (if yes, what type)	□ Yes	□ No

_____
_____
_____

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FACE

Previous face or neck surgery (if yes, what type) ….. □ Yes □ No

_____

_____

Irradiation to the face or neck ……..... □ Yes □ No
Facial paralysis or weakness ……. □ Yes □ No
Laser resurfacing or chemical peels ……..... □ Yes □ No
Any concerns about skin texture, tone or laxity……. □ Yes □ No
Any unusual scarring or keloid formation ……..... □ Yes □ No

CARDIOVASCULAR

Coronary or heart attack ……..... □ Yes □ No
Congenital heart disease ……..... □ Yes □ No
Heart murmur ……..... □ Yes □ No
Palpitations or irregular heartbeat ……..... □ Yes □ No
Hypertension ……..... □ Yes □ No
Stroke ……..... □ Yes □ No

CHEST

Shortness of breath ……..... □ Yes □ No
Chronic lung disease ……..... □ Yes □ No
Chronic cough ……..... □ Yes □ No
Asthma ……..... □ Yes □ No

PSYCHIATRIC

Has there been any recent crisis in your life? ……..... □ Yes □ No
Have you received psychiatric treatment? ……..... □ Yes □ No
Have you ever been treated for drug or
Alcohol dependency? ……..... □ Yes □ No

OTHER

Liver disorder including hepatitis or cirrhosis ……..... □ Yes □ No
Kidney or bladder disorders / chronic infections ..... □ Yes □ No
Spinal or back disorders ……..... □ Yes □ No
Previous blood clots or thrombophlebitis …….... □ Yes □ No
Any bleeding disorders in self or family ……..... □ Yes □ No
Blood transfusion ……..... □ Yes □ No
Diabetes ……..... □ Yes □ No
Autoimmune disease (Lupus, rheumatoid arthritis). □ Yes □ No
If applicable, are you pregnant ……..... □ Yes □ No

ALLERGIES

Latex allergy ……..... □ Yes □ No
Tape allergy ……..... □ Yes □ No
Any drug allergies
(including local anesthetics and codeine) ..... □ Yes □ No

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If yes, please list drug and reaction type

_____
_____
_____

MEDICATION

Are you taking aspirin or medication
Containing aspirin……..... □ Yes □ No
Have you taken any steroid preparations over the
Last year……..... □ Yes □ No
Have you taken Accutane within the last year …..... □ Yes □ No
List any medications you are presently taking and dosage (within last month)

_____
_____
_____

ANESTHESIA

Have you or anyone in your family ever has unusual
Reactions to anesthesia (muscle weakness, jaundice
Breathing problems or unexpected fevers)?... □ Yes □ No
If yes, please explain

_____
_____
_____

SOCIAL

Do you smoke ……. □ Yes □ No
If so, how many packs a day? _____
Have you ever smoked …….. □ Yes □ No
When did you stop? _____
How long did you smoke? _____
Do you drink more than two drinks a day ……..... □ Yes □ No
Do you have any risk factors for HIV/AIDS……... □ Yes □ No

X_____
Signature

List below any specific questions you would like addressed during your consultation?

_____
_____
_____

X_____
Mark R. Murphy, M.D