LADNER FACIAL PLASTIC SURGERY

KEITH LADNER, MD - FACIAL PLASTIC & RECONSTRUCTIVE SURGERY

Date: _____

Name:_____ Age.____ Height: _____ Weight:_____ Date of Last Physical:_____

Name, Address and Phone # of Primary Physician:_____

What is your daily consumption of: Tobacco: _____ Alcohol: _____
If you have smoked in the past; how much, how long, and when did you stop? _____

Please list all previous surgery, including cosmetic, serious illnesses, or hospitalizations, including childbirth:

Operation or Hospitalization: Year: Anesthesia (local/general):

_____

_____

_____

List all current medications, including dosages. Please include all over the counter medicines such as aspirin, vitamins, etc.

_____

_____

_____

Please indicate if you have ever had or suffered from the following medical conditions:

Could you possibly be pregnant	☐ No ☐ Yes	Blood transfusion	☐ No ☐ Yes
Radiation therapy for acne as a child	☐ No ☐ Yes	Sleep Apnea	☐ No ☐ Yes
Tuberculosis	☐ No ☐ Yes	Kidney Disease	☐ No ☐ Yes
Cancer	☐ No ☐ Yes	HIV	☐ No ☐ Yes
Diabetes	☐ No ☐ Yes	Depression	☐ No ☐ Yes
Heart Disease	☐ No ☐ Yes	Gastrointestinal Problems	☐ No ☐ Yes
Lung Disease / Asthma	☐ No ☐ Yes	Hepatitis / Liver Disease	☐ No ☐ Yes
Nasal Trauma	☐ No ☐ Yes	Nasal Obstruction	☐ No ☐ Yes
Previous Nasal Surgery	☐ No ☐ Yes	High Blood Pressure	☐ No ☐ Yes
Blurred Vision	☐ No ☐ Yes	Double Vision	☐ No ☐ Yes
Dry Eyes	☐ No ☐ Yes	Mental Illness	☐ No ☐ Yes

Are you on any dietary supplements or suppressants? ☐ No ☐ Yes
If yes, please list: _____

Have you or a family member ever had a reaction to general anesthesia? ☐ No ☐ Yes

Have you or a family member ever been diagnosed with a bleeding disorder? ☐ No ☐ Yes

Drug Allergies and Sensitivities: _____

I acknowledge that I have disclosed all of my medical history known to me:

PATIENT SIGNATURE: _____ M.D. SIGNATURE:_____

DATE:_____ DATE:_____