BEST IMPRESSIONS™

PLASTIC SURGERY

"Specializing In Your Good Looks"sm

Date_____

Patient Information and History is Confidential Material -Please Print

Name:_____ Sex_____ Age____ Date of birth_____ SS#_____
First Middle Last

Address: _____ City _____ State _____ ZIP_____

HomePhone_____ WorkPhone_____ CellPhone_____ Weight_____ Height_____

May we leave a message for you at Home Yes:____ No:____ May we leave a message for you at Work Yes:____ No:____

May we have your e-mail address so that we can keep you updated on new procedures, seminars and skin care products? _____
E-Mail address_____

How did you hear about Dr. Best?_____ Your primary care physician_____

Single_____ Married_____ Widowed_____ Separated _____ Divorced_____

Employer_____ Work Address _____

Occupation_____ Supervisor_____

In case of emergency, who should be notified?_____ Parent____ Spouse____ Other _____

Next of Kin Address_____ Phone _____

Next of Kin Employer _____ Address_____

Person Responsible for Payment-Name_____ Address_____

PERSONAL HISTORY

Is there any **personal** history of serious or chronic illness ? _____ Please list_____

_____

Have you ever had any operations or hospitalizations ?_____ Please list_____

_____

Please list ALL present medications, including vitamins, birth control pills, cold tablets, prescription drugs, herbal medication et cetera, if not taking any, please write NONE : _____

_____

Are you allergic to ANY medications or tape?_____ Please list _____

Do you smoke?_____ Do you use aspirin on a regular basis?_____ Have you ever been treated for mental illness? _____

Do you now, or have you ever used drugs or alcohol to excess?_____

Number of pregnancies_____ Number of children_____ Miscarriage_____ Are you pregnant?_____ Nursing?_____

Reason for today's visit _____

Have you ever had ? -Please circle

Eye disease or eye injury

Impaired vision

Double vision

Facial nerve injury or paralysis

Impaired hearing

Loss of smell

Nasal fracture or injury

Blackout spells or seizures

Respiratory or lung problems

Chronic cough

Pneumonia or asthma

Heart attack or disease

Rheumatic fever

Bleeding tendency

High blood pressure

Diabetes

Numbness in hands or feet

Hand or forearm injury of any kind

A tendency to form wide scars

A tendency to form keloids (scar tissue)

Severe concussion or head injury

Chronic nausea or vomiting

Chronic diarrhea or constipation

Blood in stools

Hepatitis

Bladder or kidney infection

Skin disease

Cancer of any kind

Blood in your urine

Gonorrhea or syphilis

Arthritis

Bone disease or tumors

Prostate disease (males only)

Herpes

I authorize Best Impressions Plastic Surgery/David C. Best, MD to provide medical care reasonable by today's standards. I authorize and consent for Best Impressions Plastic Surgery/David C. Best, MD to use patient health information for treatment purposes. I authorize Best Impressions Plastic Surgery/David C. Best, M.D. to correspond with me through online communication. I realize that accurate medical information is absolutely essential to safe and proper medical care and have answered the questionnaire honestly and to the best of my ability.

Signature _____ Date_____

Relationship to the patient _____

_____