Personal Information

Thank you for selecting Toft Facial Plastic Surgery! We will always offer you the most up-to-date facial rejuvenation options available. To help us meet your needs, please fill out these forms.

❑ **Male**
❑ **Female**
❑ **Single**
❑ **Married**

Patient's name ______ Your nickname ______

Birth date ______ Social Security number ______

Name of spouse ______ Patient's employer ______

Patient's occupation ______

Patient's address ______

City ______ State ______ Zip ______

My goals for this consultation include discussing: ______

______

______

______

My time frame for surgery is: ______

I have determined a budget for my surgery and want to work within it ❑ Yes ❑ No

Who may we thank for referring you to our office?

❑ My Doctor, Dr.: ______ ❑ My Friend: ______

❑ My Relative: ______ ❑ Sacramento Magazine ______

❑ Yellow Pages advertisement: ______ ❑ Internet Search Engine: ______

❑ Other: ______

Responsible party (if under the age of 18)

Responsible party's name ______ Relation to patient ______

Birth date ______ Social Security number ______

Drivers license number ______

Parent/Guardian signature ______ Date ______

How may we reach you?

Home phone number ______ Work phone number/extension ______

Cell phone number ______ Pager number ______

E-mail address ______

Would e-mail appointment reminders be helpful? ❑ Yes ❑ No

Where do you prefer to receive calls/messages? ❑ Home phone ❑ Work phone ❑ Cell phone ❑ Pager

When is the best time to reach you? Time:______

Days: ❑ Mon. ❑ Tues. ❑ Wed. ❑ Thurs.

Medical Concerns

We are here to provide the safest, most comprehensive facial plastic surgery. In order to do so, we need even more information about you. The medications you are presently taking and the health problems you may have could affect how we develop your treatment plan. We know what a tedious process this is, so thank you in advance for your cooperation.

General Medical

Medical illnesses you are being treated for:

____

____

____

____

____

List all operations you have had, and the dates on which they occurred:

____

____

____

List all hospitalizations, other than operations:

____

____

____

Medications

What medications are you taking— including "over the counter" products, such as aspirin, homeopathic or vitamins?

____

____

____

____

____

Are you allergic to:

❑ Penicillin ❑ Codeine ❑ Latex
❑ Metals ❑ Other (please list):______________
❑ No known allergies

Have you ever taken steroids or cortisone?

❑ Yes ❑ No

Social History

Do you smoke or use tobacco products?

❑ Yes ❑ No

How many packs per day?____________

Do you drink alcohol?

❑ Yes ❑ No

How many drinks per week?____________

General Questions

Have you ever had ulcers of the mouth (such as Herpes)?

❑ Yes ❑ No

Do you regularly sunbathe?

❑ Yes ❑ No

If yes, do you tan even or blotchy?________________

Do you use "tanning in a bottle"?

❑ Yes ❑ No

Have you ever had X-ray treatments to your face and/or neck for acne or any other reason?

❑ Yes ❑ No

Have you ever had dermabrasion or a chemical peel?

❑ Yes ❑ No

If yes, where?____________________________

When?________________________________

By whom?______________________________

Are you currently or have you ever used Retin-A?

❑ Yes ❑ No

If yes, when started?__________ Stopped?__________

Are you currently or have you ever used Accutane?

❑ Yes ❑ No

If yes, when started?__________ Stopped?__________

Of what ancestry are you?____________________

Immune System

❑ Lupus ❑ Organ transplant ❑ HIV
❑ AIDS ❑ ARC

Bleeding

Do you bleed easily? (Aspirin can cause this.)

❑ Yes ❑ No

Are you on Coumadin or other blood thinners?

❑ Yes ❑ No

Do you have Hepatitis?

❑ A ❑ B ❑ C ❑ D ❑ jaundice

Diabetes

Do you have diabetes?
❑ Yes ❑ No

If yes, which type?
❑ Type 1 ❑ Type 2

Heart Problems

What is your normal blood pressure?________________

Have you ever had any of the following conditions?
❑ Heart murmur ❑ Stroke
❑ Heart attack ❑ Rheumatic fever
❑ Angina ❑ Heart valve malfunction

Do you have a pacemaker?
❑ Yes ❑ No

Have you ever had any other heart surgery?
❑ Yes ❑ No

Breathing and Lungs

Do you have any of the following problems?
❑ Snoring (ask your spouse)
❑ Sinus problem ❑ Seasonal allergies
❑ Bronchitis ❑ Asthma

Is it hard to breathe normally through your nose?
❑ Yes ❑ No

Have your tonsils been removed?
❑ Yes ❑ No

Neuromuscular

Are you nervous? (not just because you are in a doctor's office)
❑ Yes ❑ No

Do you have a mental health disorder?
❑ Yes ❑ No
What is it?______________________________

Do you get frequent headaches or earaches?
❑ Yes ❑ No

Pregnancy

Are you pregnant?
❑ Yes ❑ No

Are you taking birth control pills?
❑ Yes ❑ No
Antibiotics can interfere with birth control pills and can cause them not to work.

Physicians, Physical Therapists and Chiropractors

Please list everyone who is treating you at this time.

Name: ______________________________
Phone: ______________________________
Treatment: ______________________________

Name: ______________________________
Phone: ______________________________
Treatment: ______________________________

Name: ______________________________
Phone: ______________________________
Treatment: ______________________________

Is there anything else you feel we need to know about the systems of your body?

____
____
____
____
____
____
____
____

The information I have just supplied is correct to the best of my knowledge. I understand that it will be held in the strictest confidence and be used for the development of my treatment plan. I give my permission to Dr. Toft or his staff to use any photos of my treatment for lecturing or educational purposes. I also understand that Dr. Toft's office is HIPPA compliant.

Signature ______________________________
Date ______________________________