PORTLAND FACE DOCTOR

Updated 12/4/2024

Health History Form *(please fill out all fields)*

First Name | Last Name | Date of Birth

E-mail Address | Phone Number

Home Address

Please describe your desired aesthetic goals.

Current Height | Current Weight | BMI

Please list all current medications and supplements (both over the counter and prescription)

Any allergies to medications? If yes, please describe the reaction and the last year it happened.

Are you a current or former smoker? If yes, please list how many per day and for how many years.

Circle Yes or No for the following questions about your medical history:

Prior MRSA infection	Yes	No
Type 1 or Type 2 Diabetes	Yes	No
Heart conditions (arrhythmia, etc)	Yes	No
Previous Heart Surgery	Yes	No
Asthma	Yes	No
Sleep Apnea	Yes	No
Dry Eyes	Yes	No
Difficulty Breathing	Yes	No
Prior Lung Surgery	Yes	No
Been prescribed a blood thinner	Yes	No
Previous blood clot/DVT/PE	Yes	No
Currently taking GLP-1 (Ozempic, etc.)	Yes	No
Cold Sores	Yes	No

PORTLAND FACE DOCTOR

Updated 12/4/2024

What previous surgeries have you had? Please also include the approximate year.

Any issues with anesthesia with prior surgery? If yes, please list the specific problem.

Are you very concerned about the appearance of some part(s) of your body that you consider especially unattractive?	Yes	No
If yes, do these concerns preoccupy you? That is, you think about them a lot and wish you could think about them less?	Yes	No

If yes, what are they? What specifically bothers you about these body parts?

_____

What effect has your preoccupation with your appearance had on your life?		
Caused a lot of distress or emotional pain	Yes	No
Has it significantly interfered with your social life? How?	Yes	No
Has your defect(s) significantly interfered with your school work, your job, or your ability to function in your role at home?	Yes	No
Do you avoid things because of your defect?	Yes	No
Have the lives or normal routines of your family or friends been affected by your appearance concerns?	Yes	No
Are you very concerned about the appearance of some part(s) of your face that you consider especially unattractive?	Yes	No

If you answered yes to any of the above 6 questions, please elaborate:

_____

How much time do you spend thinking about your defect(s) per day on average? (add up all the time you spend, and circle one)

(A) Less than 1 hour per day
(B) 1-3 hours per day
(C) More than 3 hours per day

Preferred pharmacy for any medications related to your care:

_____