Welcome to Givens Plastic Surgery

Date:_____ Name:_____ Date of Birth: _____ Age:____
First MI Last

Gender: □ M □ F Phone Number:_____ Email:_____

Home Address: _____

City, State, Zip: _____

Occupation:_____ **Emergency Contact:**_____
Name **Relationship** **Phone Number**

Procedure(s) of Interest

___ Austin Custom Lift
___ Brow Lift
___ Eyelid Lift
___ Lip Lift
___ Facial Liposuction
___ Fat Grafting
___ Facial Implants
___ Rhinoplasty
___ Revision Rhinoplasty
___ Chin Implant
___ Laser Resurfacing
___ Scar Revision
___ Earlobe Repair
___ Lesion Removal
___ Botox & Dysport
Area(s): _____
___ Botox Facial
___ Filler Refinement
Area(s): _____
___ PRP □ Facial □ Hair
___ Exosomes □ Skin □ Hair/Brow

OTHER: _____

How did you hear about us? (GFPS website, Google, Instagram, IGTV, Facebook, YouTube, TV, Friend/Family, Physician)

_____

Patient Authorization & Consent

- I am at least 18 years of age or accompanied by an adult. I consent to examination or treatment by Dr. Givens and her staff.
- Information contained here will NOT be released unless you have authorized Givens Facial Plastic Surgery and Dr. Givens to do so. All questions should be answered to the best of your knowledge. The information provided by you will be used by Dr. Givens in making decisions regarding your care.
- I understand that I am responsible for my insurance co-pay and deductibles on the day of my visit and am obligated to notify the practice immediately of any changes to my coverage.
- I authorize Dr. Givens or her designated staff member to access my Health Records.
- I authorize Dr. Givens and her staff to telephone or otherwise contact me (or responsible party) regarding appointments, treatment information, and/or any other details related to patient therapy and treatment.

Patient/Guardian Signature:_____ **Date:**_____

MEDICAL & SURGICAL HISTORY

Victoria B Givens, MD

Ethnicity:_____ Height:_____ Weight:_____ Other:_____

Please select any of the following medical conditions you have or have had in the past. ☐ NONE

- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Heart Disease/CAD
- ☐ Heart Murmur
- ☐ Chest Pain/Angina
- ☐ Heart Attack—year:____
- ☐ Pre-diabetes: A1C____
- ☐ Diabetes: A1C____
- ☐ Hypoglycemia
- ☐ Chronic Cough
- ☐ Asthma
- ☐ Lung Disease_____
- ☐ DVT/PE—year_____
  - ☐ IVC Filter—year:_____
- ☐ Reflux/Heart Burn
- ☐ Stomach Ulcers
  - ☐ Ulcer Bleeds—year:_____
- ☐ Excessive Scarring/Keloids
- ☐ Lupus
- ☐ Scleroderma
- ☐ Cancer:_____
  - ☐ Chemotherapy_____
  - ☐ Radiation_____
- ☐ Immunosuppressive Drugs
- ☐ Anemia
- ☐ Blood Transfusions
- ☐ HIV/AIDS
- ☐ Hepatitis:_____
- ☐ Clotting Disorder_____
- ☐ Kidney Disease
- ☐ Staph Infections/MRSA
- ☐ Cold Sores/Fever Blisters
- ☐ Skin Condition/Shingles
- ☐ Drug Dependency
- ☐ Alcohol Addiction
- ☐ Epilepsy/Convulsions
- ☐ Anxiety ☐ Depression
- ☐ Bipolar ☐ Schizophrenia
- ☐ Eating Disorder
- ☐ Other Psychiatric Dx
  - ☐_____
- ☐ Migraines ☐ TMJ
- ☐ Sleep Apnea
- ☐ Glaucoma
- ☐ Dry Eye Syndrome
- ☐ Thyroid Disorder
- ☐ Myasthenia Gravis
- ☐ Raynaud's Syndrome

List any medical conditions that have NOT been covered and/or additional information that you believe would be important for us to know. _____

Medical Questionnaire

1. **Have you ever taken Accutane?** ☐ YES ☐ NO If stopped, when?_____
2. **Are you pregnant?** ☐ YES ☐ NO Date of Last Menstrual Cycle:_____
3. **Have you ever had a coronary stent placed?** ☐ YES ☐ NO Physician Name:_____
4. **Do you have any of the following?** ☐ NONE
   ☐ Loose or Chipped Teeth ☐ Caps ☐ Veneers ☐ Dental Implants ☐ Dentures ☐ History of dental infections
5. **Tobacco/Inhalational & Alcohol Use**
   - Do you smoke? ☐ YES ☐ NO # of packs/day:_____ If stopped, when?_____
   - Does anyone in your household smoke? ☐ YES ☐ NO
   - Do you use a nicotine patch/substitute or other tobacco product (ie, dip)? ☐ YES ☐ NO
     If yes, which product(s)?_____
   - Do you use any inhalational products (ie, vaping, E-cig, THC/Marijuana)? ☐ YES ☐ NO
     If yes, which product(s)?_____
   - Do you drink or take alcohol? ☐ YES ☐ NO
     If yes, # of alcohol drinks/day:_____
6. **Eye History**
   - Do you require: ☐ Glasses ☐ Contacts Date of Last Eye Exam:_____
   - Do you use eye drops? ☐ YES ☐ NO If yes, how often?_____
   - Do you have any of the following symptoms associated with your eyes or eyelids? ☐ NONE
     ☐ Excessive Swelling ☐ Frequent Allergies/Irritations ☐ Dry Eyes ☐ Watery Eyes ☐ Spontaneous Tearing
   - Do you have or ever had any visual problems and/or injuries to your eyes or eyelids? ☐ YES ☐ NO
     Explain:_____
   - Have you had any surgery to your eyes or eyelids? ☐ YES ☐ NO *(please list under surgery section on next page)*

MEDICAL & SURGICAL HISTORY

Victoria B Givens, MD

List *all* surgeries including date of surgery (ie, year) you have had below. ☐ NONE

_____

_____

_____

Have you ever had any reaction (nausea, etc.) to local or general anesthesia? ☐ YES ☐ NO

If yes, please describe: _____

Do you have a personal or family history of malignant hyperthermia? ☐ YES ☐ NO

List *all* medications you are currently taking or have taken in the past 6 months below. ☐ NONE

MEDICATION	DOSAGE	FREQUENCY	**Include *any* of the following:**
			Birth Control Pills and Devices, Blood Pressure (lisinopril, HCTZ, losartan, norvasc, diuretics), Blood Thinners (aspirin, coumadin, warfarin), Diet Pills, Cardiac (digoxin, metoprolol, nitroglycerin), Glaucoma Drops, Diabetic (metformin, insulin), Asthma Medications, Sleeping Aids, Anti-Depressants, Pain Pills/Shots, Epilepsy Medications, Steroids

Do you take any of the following vitamins or herbal/nutritional supplements?

☐ Vitamin E ☐ Fish Oils/Omega-3s ☐ Glucosamine ☐ Gingko Biloba ☐ St. John's Wart

☐ Protein Powder ☐ Garlic Supplement ☐ Turmeric/Curcumin Supplement

**These medications are wonderful but must be stopped 2 weeks before and after surgery as they increase one's risk of bleeding.*

List *all* known allergies, as well as reactions, even to materials below. ☐ NONE

ALLERGIES	REACTIONS	**Include *any* of the following:**
		Latex, Elastic, Tape, Adhesives

Preferred Pharmacy for Medications ***Please include name, address, AND phone number**

Pharmacy Name: _____

Address: _____

Phone Number: _____

Physician Resources

1. Primary Care Physician: _____ Phone Number: _____
2. Cardiologist: _____ Phone Number: _____
3. Other: _____ Phone Number: _____

NOTICE OF PRIVACY PRACTICE

This is a notice that Givens Facial Plastic Surgery, PLLC participates with the privacy practice Health Insurance Portability and Accountability Act (HIPAA) regulations. It is our intent to protect our patients' confidentiality within all reasonable means.

The HIPAA regulations are meant to protect your personal health information. However, the practice encounters patients who appoint others to call the office to arrange appointments and take care of financial aspects of their care.

Please indicate below if there are any persons whom you may provide the practice authorization to release information regarding your appointments, medical, and/or financial information.

Name	Relationship	All Appointments Medical Financial (Please circle any that may apply)
Name	Relationship	All Appointments Medical Financial (Please circle any that may apply)
Name	Relationship	All Appointments Medical Financial (Please circle any that may apply)

I hereby acknowledge that I have been made aware of the Notice of Privacy Practices from Givens Facial Plastic Surgery, which sets forth the ways in which my personal health information may be used or disclosed by Givens Facial Plastic Surgery and outlines my rights with respect to such information. I understand that I may read a copy of it by my request.

I authorize the release of any information acquired in the course of my examination or treatment if necessary, to determine benefits.

Patient/Guardian Signature:_____ **Date:**_____