

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

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> DVT/PE—year: _____ | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> IVC Filter—year: _____ | <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Bipolar <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Heart Disease/CAD | <input type="checkbox"/> Reflux/Heart Burn | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Hepatitis: _____ | <input type="checkbox"/> Other Psychiatric Dx |
| <input type="checkbox"/> Chest Pain/Angina | <input type="checkbox"/> Ulcer Bleeds—year: _____ | <input type="checkbox"/> Clotting Disorder _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Heart Attack—year: _____ | <input type="checkbox"/> Excessive Scarring/Keloids | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Migraines <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Pre-diabetes: A1C _____ | <input type="checkbox"/> Lupus | <input type="checkbox"/> Staph Infections/MRSA | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Diabetes: A1C _____ | <input type="checkbox"/> Scleroderma | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Skin Condition/Shingles | <input type="checkbox"/> Dry Eye Syndrome |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Chemotherapy _____ | <input type="checkbox"/> Drug Dependency | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Radiation _____ | <input type="checkbox"/> Alcohol Addiction | <input type="checkbox"/> Myasthenia Gravis |
| <input type="checkbox"/> Lung Disease _____ | <input type="checkbox"/> Immunosuppressive Drugs | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> 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 & Surgical History

- YES NO **Have you ever taken Accutane?** If stopped, when? _____
- YES NO **Are you pregnant?** Date of Last Menstrual Cycle: _____
- YES NO **Have you ever had a coronary stent placed?** Physician Name: _____
- YES NO **Do you smoke?** # of packs/day: _____ If stopped, when? _____
- YES NO **Do you use a nicotine patch/substitute, other tobacco product (ie, dip), or any inhalational products including vaping, E-cig, THC/Marijuana?** If yes, which product(s)? _____
- YES NO **Do you drink alcohol?** If yes, # of alcohol drinks/day: _____
- YES NO **Do you have any of the following?**
 Loose/Chipped Teeth Caps Veneers Dental Implants Dentures History of dental infections
- YES NO **Do you require:** Glasses Contacts Date of Last Eye Exam: _____
- YES NO **Do you use eye drops?** If yes, how often? _____
- YES NO **Do you have any of the following symptoms associated with your eyes or eyelids?**
 Excessive Swelling Frequent Allergies/Irritations Dry Eyes Watery Eyes Spontaneous Tearing
- YES NO **Do you have or ever had any visual problems and/or injuries to your eyes or eyelids?**
Explain: _____
- YES NO **Have you had any surgery to your eyes or eyelids?**

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

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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 <u>any</u> 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 <u>any</u> 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. 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.

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 authorize Dr. Givens and her designated staff to access my Health Records and telephone, text, email, or otherwise contact me (or responsible party) regarding appointments, treatment information, and/or any other details related to patient treatment.
- 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 authorize the release of any information acquired in the course of my examination or treatment if necessary, to determine benefits.

Patient/Guardian Signature: _____

Date: _____