Parker A. Velargo, MD, Facial Plastic Surgery
Russell G. Hendrick, Jr., MD, Plastic Surgery
Celeste C. Gary, MD, Facial Plastic Surgery

NEW ORLEANS CENTER
FOR AESTHETICS AND PLASTIC SURGERY

PATIENT INFORMATION

First Name: _____ Last Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____ Email: _____

May we contact you by email? ☐**Yes** ☐ **No** May we contact you by text message? ☐**Yes** ☐ **No**

Date of Birth: _____ Age: _____ Marital Status: _____

Occupation: _____ Employer: _____

Who is your Primary Care Doctor? _____

Who is your Dermatologist? _____

Preferred Pharmacy: _____ Location: _____ Phone: _____

Who referred you to our practice? How did you first hear about our practice?

_____

Emergency Contact: _____ Relationship: _____

Occupation: _____ Employer: _____

Cell Phone: (_____) _____ Email: _____

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What areas of the face are you interested in improving?

☐Forehead / Brow	☐Neck	☐Skin Quality
☐Eyes	☐Chin	☐Other_____
☐Cheeks	☐Nose	
☐Jowls / Jawline	☐Ears	

What areas of the body are you interested in improving?

☐Hands	☐Abdomen	☐Vagina
☐Arms	☐Thighs	☐Other _____
☐Breasts	☐Buttock	

MEDICAL AND SURGICAL HISTORY
Height: _____ Weight: _____
☐**Yes** ☐ **No** Any recent fluctuation in weight?

List **ALL PREVIOUS SURGERIES** including any plastic or reconstructive surgery. List with dates and surgeon:

_____
_____
_____
_____
_____
_____

☐**Yes** ☐ **No** Do you or a family member have a **SENSITIVITY TO ANETHESIA** or Malignant Hyperthermia?
☐**Yes** ☐ **No** Do you or a family member have a history of **BLEEDING DISORDERS**?

Please list all drug/food/tape **ALLERGIES** and type of reaction:

_____
_____
_____

List **ALL CURRENT MEDICATIONS** including **PRESCRIPTION MEDICATIONS, HERBAL SUPPLEMENTS**, and **OVER THE COUNTER MEDICATIONS**. List dosage and frequency:

_____
_____
_____
_____
_____
_____
_____

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Please check all past and present medical conditions:

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Previous heart attack
- ☐ Murmur
- ☐ Irregular heartbeat
- ☐ Previous stroke
- ☐ Blood clots
- ☐ High cholesterol
- ☐ Poor circulation in your fingers and toes
- ☐ Bleeding disorder

IMMUNE / INFECTIOUS
- ☐ HIV
- ☐ Tuberculosis
- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ Scleroderma
- ☐ Other autoimmune disorders

EYES
- ☐ Dry eyes
- ☐ Blurred/double vision
- ☐ Cornea problems
- ☐ Glaucoma
- ☐ Thyroid eye disease
- ☐ Wear glasses / contacts

PULMONARY
- ☐ Asthma
- ☐ COPD
- ☐ Shortness of breath

HEPATIC/ RENAL
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Kidney disease

NOSE
- ☐ Nasal allergies
- ☐ Chronic sinus infections
- ☐ Difficulty breathing through nose
- ☐ Decreased sense of smell
- ☐ Previous nasal injury

ENDOCRINE
- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Thyroid disease

CANCER
- ☐ Skin cancer
- ☐ Other cancer

NEUROMUSCULAR
- ☐ Muscle weakness
- ☐ Facial paralysis
- ☐ Nerve damage
- ☐ Seizure disorder
- ☐ Spinal/back disorders

GASTROINTESTINAL
- ☐ Acid reflux
- ☐ Stomach ulcers
- ☐ Constipation or diarrhea
- ☐ Difficulty swallowing

SKIN
- ☐ Acne
- ☐ Rosacea
- ☐ Eczema
- ☐ Psoriasis
- ☐ Cold sores/herpes
- ☐ Keloids

OTHER: _____

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MEDICAL HISTORY

☐**Yes** ☐ **No** Do you take Aspirin or other blood thinners?
☐**Yes** ☐ **No** Have you been treated with Accutane in the past year?
☐**Yes** ☐ **No** Have you taken steroids in the past 3 months?
☐**Yes** ☐ **No** Have you had any COSMETIC INJECTIONS previously?
If yes, what and when? _____

SOCIAL HISTORY

☐**Yes** ☐ **No** Do you smoke or use other nicotine products? If yes, how much per day? _____
If you used tobacco in the past, for how many years? _____ Quit Date: _____
☐**Yes** ☐ **No** Do you consume caffeine? How much? _____
☐**Yes** ☐ **No** Do you exercise? If so, how often? _____
☐**Yes** ☐ **No** Do you drink alcoholic beverages? If so, weekly alcohol consumption? _____
☐**Yes** ☐ **No** Do you currently use marijuana? How often? _____
☐**Yes** ☐ **No** Do you currently use cocaine or any other illicit substances? If yes, explain: _____

PSYCHIATRIC HISTORY

☐**Yes** ☐ **No** Do you often get depressed or blue?
☐**Yes** ☐ **No** Are you considered a nervous person?
☐**Yes** ☐ **No** Are you easily upset or irritated?
☐**Yes** ☐ **No** Do you tend to hold a "grudge" when someone angers you?
☐**Yes** ☐ **No** Have you ever considered consulting a psychiatrist, psychologist or counselor?
Explain: _____

FEMALE PATIENTS ONLY

☐**Yes** ☐ **No** Are you pregnant or possibly pregnant?
☐**Yes** ☐ **No** Are you breastfeeding?
☐**Yes** ☐ **No** Do you have children? Number of children_____
☐**Yes** ☐ **No** Do you plan on having more children?
☐**Yes** ☐ **No** Do you have a family history of Breast Cancer? If yes, please indicate which family member: _____
☐**Yes** ☐ **No** Have you had a Mammogram? When? _____
If interested in breast surgery, what is your current cup size? _____ Desired cup size? _____
☐**Yes** ☐ **No** Are you still having periods?
☐**Yes** ☐ **No** Are your periods often irregular?

PRIVACY NOTICE

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.
A full copy of the notice of privacy practices is available for your review in print or digital format. The notice describes your rights to access and control of your protected health information.
By signing below, you acknowledge that you have reviewed the policy and agree to these terms.

Patient or Guardian Signature _____ Date _____