



# HILLSTROM FACIAL PLASTIC SURGERY

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_ E-mail \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Reason for Today's Visit? \_\_\_\_\_

Primary Physician \_\_\_\_\_

Referring Physician \_\_\_\_\_

Referred by: Sarasota/Bradenton Herald\_\_ Website\_\_ Around the Ranch\_\_ East County Observer\_\_  
Seminar/Lecture\_\_ Yellow Pages\_\_ Patient\_\_ Other \_\_\_\_\_

### Medical History

Please list any medical conditions not checked below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any of the following?

Asthma/lung disease

Anemia

Cancer

Diabetes

Epilepsy

Nervous/psychiatric disease

Heart Disease

Bleeding problem

Hepatitis/liver disease

Kidney or bladder problems

Venereal disease

Hypertension

List medications you are taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medications? Please list: \_\_\_\_\_

Have you had HIV testing? Yes No

Are you pregnant? Yes No

Do you smoke? Yes No How Much \_\_\_\_\_

Do you drink alcohol? Yes No How Much \_\_\_\_\_

Quit? \_\_\_\_\_

List Past Surgeries \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that consultations, office visits and all in office procedures are payable on the day service is rendered. I accept and agree to the financial policy of this office.

Patient or Guardian's Signature: \_\_\_\_\_