

Welcome to

# GARDNER FACIAL PLASTICS AND RADIANCE MEDICAL SPA

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

Have you ever had Facial Plastic Surgery: YES NO

If yes, please specify: \_\_\_\_\_

Have you ever had Botox or Filler? YES NO

If yes, date of last NEUROTOXIN injections: \_\_\_\_\_ FILLER injections: \_\_\_\_\_

Do you have history of keloid scarring? YES NO

### Medical History

Please List all chronic conditions or illnesses: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

### List all previous surgeries

### Month/Year

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

### List all current medications and dosages

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

Do you take a blood thinner: Baby aspirin, Coumadin, Eliquis, Xarelto, Plavix or Heparin? YES NO

Do you have a pain medication contract with another clinic? If yes, which Dr?: \_\_\_\_\_

Do you use a GLP-1 such as Ozempic or Semiglutide? YES NO

When was your last visit with your Primary Care Physician?: \_\_\_\_\_



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### Social History

Do you drink alcohol?: YES NO If yes, how often?: \_\_\_\_\_

Tobacco status- please circle below:

Non- smoker Current smoker Former smoker (\_\_\_\_\_ years since)

### Cardiac History

Do you have a pacemaker or defibrillator?: YES NO

Do you see a Cardiologist? YES NO Dr name: \_\_\_\_\_

Do you exercise regularly?; YES NO What type of exercise?: \_\_\_\_\_

Do you ever have heart palpitations, chest pain, ankle swelling, or significant shortness of breath? YES NO

### Are you currently experiencing or have you experienced any of the following:

Hearing loss nasal drainage swallowing pain loss of vision

ringing in ears nasal congestion voice changes

Facial pain/pressure Ear pain Sore mouth/throat Chest pain

Heart Attack A-fib Pulmonary Embolism Irregular Heartbeat

Headache Stroke Mini stroke temporary loss of vision or speech

Sleep Apnea Facial Paralysis Dry eyes/tearing

loss of sensation skin cancer depression anxiety

Hallucinations other psychiatric disorder: \_\_\_\_\_

### Any other medical history we should know? :

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