New Patient Form

Shaddix
PLASTIC SURGERY

Today's Date: _____ Name: *(Last)* _____ *(First)* _____

Address: _____ City: _____ State:_____ Zip _____

Phone: _____ Email: _____

May we leave a detailed message by: Phone **Yes / No** Email **Yes / No** Mail **Yes / No**

How did you hear about us? _____

In which services are you interested? _____

Allergies: _____

Current Medications including over-the-counter (*ie. Aspirin, ibuprofen, naproxen*) and herbal medications:

_____

_____

Are currently pregnant, trying to become pregnant, or lactating? **Yes / No**

Do you use nicotine products? **Yes / No**

MEDICAL HISTORY

Please circle any of the following that conditions that apply to you:

- Myasthenia Gravis
- Amyotrophic Lateral Sclerosis
- Multiple Sclerosis
- Autoimmune Disease
- Lupus
- Neurological Disorder
- Parkinson's Disease
- Lambert-Eaton Syndrome
- History of Cold Sores
- Problems with Scarring
- Bleeding Disorder or Easy Bruising
- Muscle Weakness
- Numbness
- Eye Disease
- Vision Problems
- Hepatitis

Have you had Botox injections in the past? **Yes / No** Approximate date of last treatment? _____

Have you had filler injections in the past? **Yes / No** Approximate date of last treatment? _____

Were you pleased with your treatment? **Yes / No** If not, why? _____

Do you feel that you have problems with your eyelids drooping **Yes / No**