

**Cincinnati Facial Plastic Surgery
Alexander S. Donath, MD
Board Certified Director
Facial Plastic & Reconstructive Surgery**

Patient Sign-In

Date _____

Patient's Name _____

Reason for today's visit _____

Procedures I would like to discuss with the doctor:

Facial Rejuvenation: Necklift Facelift Eyelid Correction Forehead/Brow Lift Fat Transfer

Nasal Surgery: Cosmetic Corrective Sinus/Septum Problems

Profile Surgery: Chin Implant Cheek Implant Facial/Neck Liposuction

Ear Surgery: Reduce Prominence Reduce Earlobe Size Repair Torn Earlobe

Skin Rejuvenation: Skin growths/moles Wrinkles Pigmentation/Age Spots Redness/Rosacea Broken Blood Vessels Roughness Scars Large pores Acne Acne Scarring Other _____

Injectables: Botox Collagen Restylane Radiesse Sculptra Lip Augmentation Juvederm Other _____

Other Procedures: Hair removal Hair Transplant Microdermabrasion Peel Chemical peel

Spider Veins: Face Legs

Facial Soft Tissue Augmentation _____ **AREAS** _____

Other: _____

Please indicate in your own words what concerns you: _____

How did you hear about our office?

Friend _____ (Name) _____ Relative _____

Co-Worker _____ Urban Active(Gold's Gym) _____

Web Site _____ Dr./Patient Referral _____ (Name) _____

Elegant Permanent Cosmetics _____ Salon _____ P&G credit union _____

Newspaper _____ (Which one) _____ Radio _____ TV _____ Other _____

Medical History (check all that applies) Date of last physical _____

Heart Disease _____ Smoking (y/n) _____ #packs _____ per _____

High Blood Pressure _____ Alcohol (y/n) _____ (frequency) _____ per _____

Heart Attack _____ (drink socially only) _____

Respiratory Condition _____ Eye problems _____ Emphysema _____

Diabetes _____ Nose problems _____ Asthma _____

Cancer _____ Ear Problems _____ Blood Disease _____

Gastro-Intestinal Condition _____ Bleeding Problems _____ Jaundice/Hepatitis _____

Urinary _____ Thyroid Problems _____ Anemia _____

Thyroid Disease _____ HIV _____ Facial Trauma _____

Have you ever consulted a professional for emotional problems? _____ If yes, What kind? Where?

Patient Sign-In Continued

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Name _____ Date _____

Allergies: _____

Medications presently taking: _____

Do you take any of the following?(Please check)

Blood Pressure Meds _____ Name of drug _____

Vitamin E _____ Ginko _____ St. John's Wort _____ Ginseg _____ Aspirin _____ Garlic _____

OTHER _____

General Surgical/ Plastic Surgery History (list all surgeries and indicate any complications)

Any complications from general or local anesthesia for yourself or any relative? Yes ___ No ___

NOTES:

Thank you for taking time to complete this very important questionnaire!!