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?

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!!