

Peter J. Abramson, M.D.  
Board Certified  
American Board of Facial  
Plastic and Reconstructive  
Surgery

Today's

Date: \_\_\_\_\_

## Patient Profile

*Welcome to Abramson Facial Plastic Surgery & Rejuvenation Center. Our goal is to provide you with the highest quality of care. The first step is to learn all we can about your medical history. Please assist us by taking a few moments to complete all pages of the form below. Our staff will be glad to help you if necessary. The care we give you can be no better than the information you provide.*

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ Marital Status: S M D Other

City, State, Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E Mail Address: \_\_\_\_\_

SS#: \_\_\_\_\_ Sex: Male Female

### Patient Employment

### Emergency Contact

Employer: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Relation: \_\_\_\_\_

Phone: \_\_\_\_\_

### Primary Insurance (if applicable)

Primary Insured Person

Name: \_\_\_\_\_ Insurance Carrier: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_

Insured SS#: \_\_\_\_\_ Policy/Group#: \_\_\_\_\_

Insured Employer: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you here about our office?

- Patient Who? We would love to thank them \_\_\_\_\_
- Magazine/Print Article Which Magazine? \_\_\_\_\_
- Internet
- Our website
- Physician referral Who? We would love to thank them \_\_\_\_\_

*Affiliated with Ear, Nose and Throat of Georgia, LLC*

# Medical Profile

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

What would you like to discuss with Dr. Abramson today?

-----  
-----  
-----

What are your concerns?

- |  |   |
|--|---|
| <input type="checkbox"/> Shape of your nose                | <input type="checkbox"/> Cheek/Lip folds            |
| <input type="checkbox"/> Difficulty breathing through nose | <input type="checkbox"/> Vertical lines around lips |
| <input type="checkbox"/> Shape of your ears                | <input type="checkbox"/> Thin Lips                  |
| <input type="checkbox"/> Jowls                             | <input type="checkbox"/> Facial Vessels             |
| <input type="checkbox"/> Drooping Neck                     | <input type="checkbox"/> "Brown Spots"              |
| <input type="checkbox"/> Wrinkles around eyes              | <input type="checkbox"/> Acne Scars                 |
| <input type="checkbox"/> Frown lines between the eyes      |   |

What procedures are you interested in?

- |   |  |
|---|--|
| <input type="checkbox"/> Threadlift                   | <input type="checkbox"/> Botox                     |
| <input type="checkbox"/> Facelift                     | <input type="checkbox"/> Restylane                 |
| <input type="checkbox"/> Necklift                     | <input type="checkbox"/> Hair Restoration          |
| <input type="checkbox"/> Endoscopic Browlift          | <input type="checkbox"/> Hair Removal              |
| <input type="checkbox"/> Cheeklift                    | <input type="checkbox"/> Facials                   |
| <input type="checkbox"/> Eyelid Lift (Blepharoplasty) | <input type="checkbox"/> Peels                     |
| <input type="checkbox"/> Nose Reshaping (Rhinoplasty) | <input type="checkbox"/> Medical Skin Care Regimen |

When did you begin to consider surgical correction? \_\_\_\_\_

Have you consulted other physicians with your concerns? Yes  No

Have you discussed this surgery with your family? Yes  No

Are they agreeable? Yes  No

## Cosmetic History

Please list all cosmetic surgeries, the Surgeon who performed them and when they were performed.

Procedure	Surgeon	Date
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----

Have you ever had any injectable fillers? (Restylane, Radiance, Collagen, Cosmoderm/Cosmoplast, Silicone etc) Yes  No

If yes, please list: \_\_\_\_\_

When was your last injection and to what area? \_\_\_\_\_

Have you ever had a Botox injection? Yes  No

If yes, what area was treated and when was your last injection? \_\_\_\_\_

-----

# Skin History

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

Please describe your history of the following:

Sun

exposure: \_\_\_\_\_

Skin Cancer: \_\_\_\_\_

Acne: \_\_\_\_\_

Other skin problems: \_\_\_\_\_

Have you ever used Retin-A? Yes  No

If yes, are you still using it? Yes  No

How often and what dosage? \_\_\_\_\_

Have you ever been placed on Acutane? Yes  No

If yes are still on it? Yes  No

Have you ever used a hormonal or cellular skin cream? Yes  No

What other skin care products are you currently using? \_\_\_\_\_

Do you ever get cold sores or fever blisters on your lips? Yes  No

## Review of Systems

Please check yes for those below that apply to you, and no for those that do not apply

Nasal Obstruction	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nasal discharge	Yes <input type="checkbox"/> No <input type="checkbox"/>
Post nasal drip	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nosebleed	Yes <input type="checkbox"/> No <input type="checkbox"/>
Snoring	Yes <input type="checkbox"/> No <input type="checkbox"/>	Facial pain	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fever/Chills	Yes <input type="checkbox"/> No <input type="checkbox"/>	Abdominal Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>
Weight Loss	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nausea/Vomiting	Yes <input type="checkbox"/> No <input type="checkbox"/>
Night Sweats	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yellow/Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>
Irritated eyes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diarrhea	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chest pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Painful urination	Yes <input type="checkbox"/> No <input type="checkbox"/>
Irregular heartbeat	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood in urine	Yes <input type="checkbox"/> No <input type="checkbox"/>
Shortness of breath	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swollen joints	Yes <input type="checkbox"/> No <input type="checkbox"/>
Wheezing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Back pain	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cough up blood	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rash	Yes <input type="checkbox"/> No <input type="checkbox"/>
Itchy skin	Yes <input type="checkbox"/> No <input type="checkbox"/>	Weakness	Yes <input type="checkbox"/> No <input type="checkbox"/>
Shaking	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fainting	Yes <input type="checkbox"/> No <input type="checkbox"/>
High stress	Yes <input type="checkbox"/> No <input type="checkbox"/>	Depression	Yes <input type="checkbox"/> No <input type="checkbox"/>
Mood swings	Yes <input type="checkbox"/> No <input type="checkbox"/>	Frequent thirst	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Bruise easily	Yes <input type="checkbox"/> No <input type="checkbox"/>
Prolonged bleeding	Yes <input type="checkbox"/> No <input type="checkbox"/>	HIV risk factors	Yes <input type="checkbox"/> No <input type="checkbox"/>

## Past Medical History

Please check yes for those illnesses you have or have had in the past, and no for those you have never had.

Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Reflux	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cataract	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hiatal Hernia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hepatitis A	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis B	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hepatitis C	Yes <input type="checkbox"/> No <input type="checkbox"/>	High blood pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Past heart attack	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fibromyalgia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Past stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gout	Yes <input type="checkbox"/> No <input type="checkbox"/>
Block arteries	Yes <input type="checkbox"/> No <input type="checkbox"/>	Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart failure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mitral Valve Prolapse	Yes <input type="checkbox"/> No <input type="checkbox"/>
Past bypass surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have a Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>
Past angioplasty	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizure disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Parkinson's disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Spinal Injury	Yes <input type="checkbox"/> No <input type="checkbox"/>	Head injury	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pneumonia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Meningitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
HIV Positive	Yes <input type="checkbox"/> No <input type="checkbox"/>	Low thyroid	Yes <input type="checkbox"/> No <input type="checkbox"/>
Overactive thyroid	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid nodule	Yes <input type="checkbox"/> No <input type="checkbox"/>
Thyroid Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bleeding disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>	Use Aspirin	Yes <input type="checkbox"/> No <input type="checkbox"/>
Use Coumadin	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other	Yes <input type="checkbox"/> No <input type="checkbox"/>

Please explain: \_\_\_\_\_

## Surgical History

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

Please list all non-cosmetic surgeries

Procedure	Date
-----	-----
-----	-----
-----	-----

## Medications

Please list all medications you are currently taking and the dosage:


Do you have any drug allergies? Yes  No  Know Drug Allergies

If yes, please list the drug and the reaction you have had to it

-----  
 -----

Please list any other allergies

-----

Have you ever been treated for a Psychiatric illness? Yes  No

If yes, who treated you?

-----

## Family History

Please check yes for those illnesses that are present in your immediate blood relatives (parents, children or siblings)

Heart attack / disease Yes  No  High blood pressure Yes  No  Hearing loss Yes  No   
 Blocked arteries Yes  No  Diabetes Yes  No  Sickle cell / trait Yes  No   
 Past stroke Yes  No  Thyroid problems Yes  No  Allergies Yes  No   
 Bleeding problems Yes  No  Cancer Yes  No  Asthma Yes  No

Other family illness: if yes, please list:

-----  
 -----  
 -----

## Social History

You smoke \_\_\_ packs of cigarettes a day or you smoked \_\_\_- packs per day, then quit \_\_\_- years ago.

You consume \_\_\_ alcoholic beverages  per day  per week  month

You consume \_\_\_ caffeine beverages per day

You consume \_\_\_\_ glasses of water per day  
Is there a chance you may be pregnant?    Yes     No

*Affiliated with Ear, Nose and Throat of Georgia, LLC*