FACE COSMETIC +
RECONSTRUCTIVE SURGERY

PERSONAL INFORMATION SHEET

Today's Date: MM/ _____ DD/ _____ YR/ _____

Name: (first) _____ (last) _____

☐ Male ☐ Female ☐ Transgender (Pronouns: _____)

Date of Birth: MM/ ____ DD/ ____ YR/ _____ Health Card Number: _____

Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Phone: (Mobile) _____ Next of Kin: Name: _____

(Home) _____ Phone: _____

(Work) _____ Relationship: _____

Family Doctor: _____ Pharmacy: _____

Occupation: _____

Medical Health History:

Medical Problems/Diagnosis	Medications	Surgeries
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you:

Smoke cigarettes? ☐ Yes ☐ No If yes, how often? _____

Consume Alcohol? ☐ Yes ☐ No If yes, how often? _____

Use Recreational Drugs? ☐ Yes ☐ No If yes, how often? _____

Do you have any allergies? ☐ Yes ☐ No

If yes, please explain: _____

CONTINUED ON REVERSE SIDE

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Are you currently pregnant or breastfeeding? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Do you have any metal implants (includes dental)? ☐ Yes ☐ No

Have you taken Accutane or any anticoagulants in the past 6 months? ☐ Yes ☐ No

Do you have a history of neurological disorders? ☐ Yes ☐ No

Do you have a history of immune system disorder? ☐ Yes ☐ No

Do you have a history of cold sores, fever blisters, Herpes I or II? ☐ Yes ☐ No

If yes, when was your last outbreak? _____

Have you ever had any skin treatments such as laser, microdermabrasion, chemical peels, or injections? ☐ Yes ☐ No

If yes, what treatments have you had? _____

_____

If you have received anti-wrinkle injections (Botox, Dysport, etc) or dermal fillers in the past, when was your last treatment? _____

Email Address: _____

When necessary, can we email you pre-treatment information and follow-up with you using the contact information you have listed above? Email: ☐ Yes ☐ No Phone: ☐ Yes ☐ No

How did you hear about The Face Institute? _____

Date: _____ Print Name: _____

Signature: _____