STANISLAW

FACIAL PLASTIC SURGERY CENTER

Date: _____
Name:_____
Date of Birth: _____
Current Age: _____

Area(s) of Concern:

_____
_____
_____
_____

Have you EVER had fillers injected into your face? **Yes / No**
If yes, what type of filler(s)?

_____
_____
_____

If yes, what are(a)s of your face?

_____
_____
_____

Have you EVER had Botox, Dysport, Xeomin, etc., injected into your face? **Yes / No**
If yes, in what areas of your face have you had the injections?

_____
_____
_____

Do you have any allergies to any medication, latex, or tape? **Yes / No**
If so, what are you allergic to, and what was the reaction?

_____
_____
_____

Are you, or could you be pregnant? **Yes / No**
Are you currently breast feeding? **Yes / No**
Do you have a history of (C. Diff.) Clostridium Difficile Diarrhea? **Yes / No**
Do you have a history of (MRSA) Methicillin Resistant Staph Aureus? **Yes / No**
Are you taking any blood thinners: **Yes / No**
Have you ever taken the medication Accutane? **Yes / No**
If yes, when did you take the Accutane? _____
Do you have any artificial joints? **Yes / No**
Do you have a history of diabetes? **Yes / No**
Do you have a history of dry eyes? **Yes / No**
Do you have a history of glaucoma? **Yes / No**

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Do you or have you ever smoked? **Yes / No**
If yes, how many packs a day: _____
If yes, for how many years: _____
If you quit, when did you quit? _____
Please list all your medications, vitamins, or herbal supplements that you are taking currently:

_____
_____
_____
_____

Please list any medical conditions you have had, or you may have currently:

_____
_____
_____
_____

Please list any surgeries you have had in the past:

_____
_____
_____

Consent for Release of Information/Assignment of Benefits

I authorize Paul Stanislaw, Jr., MD to release any information pertaining to my diagnosis and treatment to my Primary Care Physician or to any physician that may need to be consulted.

I understand that Stanislaw Facial Plastic Surgery Center, LLC does not participate with any medical insurance, Medicare, or Medicaid. I understand that I am personally financially responsible for any fees that Stanislaw Facial Plastic Surgery Center, LLC may assess for any services he has rendered.

Signed: _____ Date: _____
PATIENT SIGNATURE

The above information was reviewed and confirmed with the patient.

Signed: _____ Date: _____
PAUL STANISLAW, JR., MD., FACS