JOHN P. GUSTE MD

PLASTIC & RECONSTRUCTIVE SURGERY

Name:_____ Date of Birth:_____ Age:_____

Address: _____City_____ZIP_____

Phone:_____ Email:_____

SSN:_____ Insurance:_____

Reason For Visit:_____ Occupation: _____

Height: _____ Weight: _____ Bra Size (if applicable): _____

Emergency Contact:_____ Phone:_____

Past Medical History: *Circle* High Blood Pressure Diabetes Heart Disease Arrhythmia Bleeding Disorder Clotting Disorder Thyroid Problem Stroke Neurologic Disorder Endocrine Disorder

Other:_____

Past Surgical History: _____

_____

Allergies: _____

Social History: Do you smoke, use tobacco products, vape, or use patches or nicotine-containing gum? *Circle* Yes No If yes, how much and how often?

_____

Do you drink alcohol? *Circle* Yes No If yes, how much and how often?

_____-

Family History: *Circle* Breast Cancer Ovarian Cancer Heart Disease Diabetes Bleeding Disorder Clotting Disorder Reaction to Anesthesia

Other: _____

Medications (including vitamins and herbal supplements):_____

_____

_____

_____

Who referred you? _____

REVIEW OF SYSTEMS

EYE

Visual loss (one or both eyes)	☐Yes	☐No
"Dry" eyes	☐Yes	☐No
Itching or irritation of eyes	☐Yes	☐No
Blurred or double vision	☐Yes	☐No
Closed or lazy eyes	☐Yes	☐No
Cornea Problems	☐Yes	☐No
Wear glasses or contacts	☐Yes	☐No
Previous eye or eyelid surgery (if yes, what type)	☐Yes	☐No

NOSE

Difficult breathing through nose	☐Yes	☐No
Previous injury to nose	☐Yes	☐No
Nasal allergies	☐Yes	☐No
Nose bleeds	☐Yes	☐No
Sinus conditions	☐Yes	☐No
Previous nasal or sinus surgery (if yes, what type)	☐Yes	☐No

FACE

Previous face and neck surgery (if yes, what type)	☐Yes	☐No
Irradiation to face or neck	☐Yes	☐No
Facial paralysis or neck	☐Yes	☐No
Facial skin problems	☐Yes	☐No

CARDIOVASCULAR

Coronary or heart attack	☐Yes	☐No
Heart murmur	☐Yes	☐No
Palpitations or irregular heart beat	☐Yes	☐No

CHEST

Shortness of breath	☐Yes	☐No
Chronic lung disease	☐Yes	☐No
Chronic cough	☐Yes	☐No
Asthma	☐Yes	☐No

PSYCHIATRIC

Have you received psychiatric treatment?	☐Yes	☐No
(if yes, were you hospitalized?)	☐Yes	☐No
Has there been any recent crisis in your life?	☐Yes	☐No
Have you ever been treated for drug or alcohol dependency?	☐Yes	☐No

OTHER

History of herpes or fever blisters	☐Yes	☐No
Liver disorder including hepatitis or cirrhosis	☐Yes	☐No
Kidney or bladder disorders or chronic infections	☐Yes	☐No
Spinal or back disorders	☐Yes	☐No
Any bleeding disorders in self or family	☐Yes	☐No
Blood transfusion	☐Yes	☐No
Autoimmune disease (Lupus, Rheumatoid Arthritis, etc.)	☐Yes	☐No
Any unusual scarring of keloid formation	☐Yes	☐No
If applicable, are you pregnant?	☐Yes	☐No
Are you taking aspirin?	☐Yes	☐No
Have you taken any steroid preparations over the past year?	☐Yes	☐No
Have you ever used Acutane?	☐Yes	☐No
If so, when was it discontinued?	☐Yes	☐No

_____

Signature

List below any questions you would like to have answered during your consultation.

_____

_____

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Guste Plastic and Reconstructive Surgery's Notice of Privacy Practices. By signing below, I am *only* giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Type or Print) Date

_____

Signature

Patient Consent Release Form

I hereby grant permission for the use of any of my medical records including illustration, photographs or other imaging records created in my case, for use in examination, credentialing and or certified purposes by the American Board of Plastic Surgery, Inc.

_____
Patient Signature

_____
Print Patient Name

_____
Witness Signature

_____
Print Witness Signature

_____
Date