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

Today's Date:_________

Patient Profile

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

Employer: ___________________

Phone: ______________________

Emergency Contact

Name: __________________________
Relation: ________________________
Phone: __________________________

Primary Insurance (if applicable)

Primary Insured Person
Name: __________________________
Date of Birth: ____________________
Insured SS#: _____________________
Insured Employer: ________________

Insurance Carrier: _________________
Insurance ID#: ____________________
Policy/Group#: ___________________

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__________________

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Name: ______________________
DOB: ______________________

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.

Medical Profile

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

____

____

What are your concerns?

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

What procedures are you interested in?

- ☐ Threadlift
- ☐ Facelift
- ☐ Necklift
- ☐ Endoscopic Browlift
- ☐ Cheeklift
- ☐ Eyelid Lift (Blepharoplasty)
- ☐ Nose Reshaping (Rhinoplasty)
- ☐ Botox
- ☐ Restylane
- ☐ Hair Restoration
- ☐ Hair Removal
- ☐ Facials
- ☐ Peels
- ☐ 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** ☐
Have you brought old photographs with you today?	**Yes** ☐	**No** ☐
Have you received our information packet?	**Yes** ☐	**No** ☐

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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

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 of fever blisters on your lips? **Yes** ☐ **No** ☐

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Review of Systems

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

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

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

Please explain:_________________________

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Surgical History

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? ____

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** ☐

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