



Office of Paul M. Gardner, MD, FACS

Patient Information as of _____ (enter today's date)

Patient Name _____

Birth date _____ / _____ / _____ Gender _____ Height _____ Weigh _____

Address _____

City/State/Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail _____ Please check if you would like to be removed from our mailing list.

Any restrictions for contacting you? No Yes Contact Restrictions: _____

Marital Status: Single Married Widowed Divorced Separated Partner Other _____

How did you hear about Gardner Plastic Surgery? (Mark all that apply)

Gulfshore Life Magazine Yellow Pages Website: _____

Friend/Relative, Please name _____ Doctor, Please name _____

Other _____ If you were referred by a specific person, may we thank them? Yes No

Employer/ School: _____ Occupation: _____

Primary Care Physician: _____ Phone Number: _____

Responsible Party or Emergency Contact

Full Name _____

Relationship to Patient _____ Birth date _____ / _____ / _____

Address _____

Home Phone _____ Work/Cell Phone _____

I, _____, authorize payment of Medical Benefits to Paul M. Gardner, MD, FACS, and agree to release information necessary for processing. I agree to be responsible for payment of services and reasonable costs of collection. I authorize the release of my Medical Records to Paul M. Gardner, MD, FACS.

Signature of Patient: _____

Medical History Record

Reason for visit (chief complaint) _____

If symptoms present, please explain and state when they first appeared

Past History:

Previous surgeries and

dates: _____

Previous anesthetic/surgical problems:

General Medical History (Please circle YES or NO):

Yes/No- high blood pressure

Yes/No- heart disease or attack

Yes/No- chest pain or shortness of breath

Yes/No- stroke

Yes/No- asthma

Yes/No- glaucoma, double vision, eye pain

Yes/No- history of deep venous thrombosis (blood clot)

Yes/No- depression, anxiety, mood swings, loss of appetite

Yes/No- back pain, joint pain/swelling, numbness of arms or legs

Yes/No- easy bruising, swollen lymph glands

Yes/No- have you taken ibuprofen, aspirin, or blood thinning agents in the past two weeks? (Avoid for two weeks before and after surgery)

Yes/No- do you have prolonged bleeding when cut? (e.g. Hemophilia) If yes, please explain: _____

Yes/No- have you formed excessive or unsatisfactory scars in the past? Keloids?

Yes/No- Have you ever received treatment for a mental condition, emotional problem or depression?

Yes/No- herpes or cold sores

Yes/No- fainting or blackout episodes

Yes/No- ulcer disease or abdominal problems

Yes/No- hepatitis If so, circle A B or C

Yes/No- HIV or AIDS

Yes/No- diabetes

Yes/No- Other significant illness? If so, please describe: _____

Yes/No- excessive thirst or hunger

Yes/No- seizures, loss of balance or slurred speech

Current Medications (list all including aspirin, birth control, vitamins and/or supplements):

Medication	Dose/Strength	Frequency taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes/No- Do you smoke? If yes, _____ packs per day

Yes/No- Did you ever smoke? If yes, _____ years ago

Yes/No- Do you drink alcohol? If yes, _____ drinks per day/week or only occasional.

Allergies: (Please list any and all) _____

Any additional information not listed on this form we should know about? _____

I attest the above history is completed to the best of my knowledge and understand and accept that my failure to disclose any of the above information can adversely affect a prescription course of treatment to meet my goals, my safety, or the outcome of any treatment I elect to undergo with Dr. Gardner and/or any member of staff.

Signature of Patient: _____ Date: _____

Cosmetic Concerns:

I have the following concerns/interests:

Aging appearance of my:

- Skin
- Face
- Eyes
- Lips and Mouth
- Neck
- Double Chin
- Facial folds and creases
- Fine lines and wrinkles
- Sun damage
- Skin tone

Breast:

- Size
- Shape
- Position, sagging
- Symmetry between my breasts

Body:

- Arms
- Back
- Breast
- Upper Abdomen
- Lower Abdomen
- Buttocks
- Hips
- Inner Thighs
- Outer Thighs
- Legs
- Excess Fat Deposits
- Exaggerated curves
- Lack of defined curves

Facial appearance/proportion of my:

- Eyes
- Chin
- Cheeks
- Lips
- Jaw

Other:

- Facial/Body spider veins
- Irregular Scars
- Moles, lesions or other growths
- _____

I am here today because I: _____

My goals are to improve my appearance by: _____

I would describe the present condition(s) I wish to improve as: _____

Have you ever had any of the following treatments?

- Botox®
- Filler Injections (Radiesse, Restylane, Juvederm)
- Peels
- Laser Resurfacing
- Microdermabrasion
- Other: _____

I use the following daily skincare: _____

Have you ever had a consultation with a plastic surgeon? _____

Is there anything you wish to tell Dr. Gardner that you do not wish to include in this form? _____



Cosmetic Patient Financial Policy

We consider it a privilege that you have chosen Gardner Plastic Surgery for your cosmetic concerns. We strive to inform you of all medical aspects of your care, and would like to advise you of our financial policy as well.

To secure a surgery date, a 10% deposit is necessary. The scheduled date is not confirmed until deposit is received.

All balances for surgery are collected at the pre-operative appointment. Generally pre-operative appointments are scheduled two weeks prior to your surgery date.

At Gardner Plastic Surgery we accept: cash, cashier checks, MasterCard, Visa, and personal checks. Personal checks are only accepted as a surgery payment a minimum of two weeks before surgery date.

Patient Signature: _____

Patient Name: _____

Date: _____