THOMAS FUNCIK, MD

Coastal Facial Plastic Surgery

Historical Data Sheet

Patient's Name: _____ Date: _____

Which procedure(s) are you interested in?

_____ Charleston Custom Lift®
_____ Lowcountry Lid Lift®
_____ Cosmetic Rhinoplasty (Nose)
_____ Forehead lift
_____ Otoplasty (Ears)
_____ Chin Augmentation
_____ Cheek Augmentation
_____ Fat transfer
_____ Oral Commissuroplasty
_____ Removal of facial sun spots (hyperpigmentation)
_____ Dysport®/Botox®
_____ Restylane®/Juvederm®/Belotero®
_____ Perlane®
_____ Sculptra Aesthetic®
_____ Scar Revision
_____ Removal of cyst, mole, skin cancer etc.
_____ Parisian Peel
_____ VI Chemical Peel
_____ Rejuvapen ®
_____ Other _____

Have you consulted with another doctor in regards to this type of procedure Yes No
Have you had any previous cosmetic surgery? Yes No
If yes, please state what type of procedure _____and when performed _____
Who performed the surgery? _____

Medical History

When was your last physical examination? _____
Who is your Internist/Family Doctor? _____
Who is your OBGYN? _____ N/A _____
List allergies to any medications and reactions: _____
_____
_____
Have you had any reaction to local or general anesthesia? _____
Explain: _____
Are you taking any over the counter or prescription medications? Yes _____ No _____
List names and Dosage: _____
_____
_____
Do you take Vitamins or supplements regularly? _____
List them: _____
Are you pregnant at present or trying to conceive? _____ N/A _____
When was your last menstrual cycle? _____
Have you ever taken Accutane (for acne)? _____
Do you take Aspirin, Advil, Motrin, or any other blood thinners? _____
Do you have a history of bleeding or excessive bruising? _____
Have you ever had herpes, fever blisters, or cold sores? _____
Have you ever had surgery or injuries to or around the face, neck or eyes? _____
If so, when _____ Describe injury _____
Have you or any member of your household had an infection with MRSA? _____

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Have you or any member of your immediate family been affected by any of the following condition?
√ boxes and identify who by relationship:

_____ Heart trouble _____
_____ High blood pressure_____
_____ Diabetes _____
_____ Bleeding _____
_____ Poor Healing _____
_____ Psychiatric problems _____
_____ Nervous problems _____
_____ Thyroid _____
_____ Arthritis _____
_____ Excessive bruising _____
_____ Excessive scaring _____
_____ Tuberculosis _____
_____ Other _____

Have you ever had any surgeries we should be aware of? √ boxes, give dates, and specifics regarding type:
_____
_____
_____
Were there any complications to any of the above mentioned procedures _____
_____
Number of pregnancies _____ Number of deliveries _____
Ages of each child: _____

No	Yes	Do you have hay fever, asthma, or allergies?
No	Yes	Do you have chest pains with stress or exertion?
No	Yes	Do you have stomach trouble or ulcers?
No	Yes	Have you ever had liver, gallbladder trouble, or yellow jaundice? (circle one)
No	Yes	Do you have skin irritations, rashes or sensitivity to adhesive tape?
No	Yes	Do you have headaches or dizzy spells?
No	Yes	Has any part of your body ever been paralyzed?
No	Yes	Do you ever have convulsion or seizures?
No	Yes	Have you ever had loss of vision?
No	Yes	Do you have dry eyes?
No	Yes	Do you suffer with blurred vision?
No	Yes	Are you being treated for glaucoma?
No	Yes	Were you ever treated for anemia?
No	Yes	Have you ever been treated for a venereal disease?
No	Yes	Have you ever taken hormones or thyroid medication?
No	Yes	Do you smoke?_____ per day _____ how long
No	Yes	Do you drink more then 3 cups of coffee a day?
No	Yes	Do you usually drink two or more alcoholic beverages per day?
No	Yes	Do you often get depressed?
No	Yes	Have you ever had a nervous breakdown or panic attack?
No	Yes	Have you ever received medical attention for a nervous condition?
No	Yes	Are you fearful of doctors or dentists?
No	Yes	Do you have any medical problems that have not been covered?
No	Yes	Are there any private medical conditions such as drug use, HIV infection, etc. That you would like to discuss with Dr. Funcik privately?

Signature: _____ Date: _____

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