CHARLESTON
Facial Plastic Surgery
DAVID RODWELL, MD

PATIENT INFORMATION

date: ______________

Last Name ____________________________ First Name ________________________ MI ______________

Address ____

City ____ State ___________________ Zip _____________

Cell Phone _(______)_____________________________ Home Phone _(______)______________________

Email ____ May we contact you by email? Yes No

Date of Birth ___________________________________ Age ____________ Marital Status _____________

Patient's Occupation ____________________________ Employer __________________________________

Who referred you to our office? ____

Spouse or Parent's Name ____

Occupation _____________________________________ Employer _________________________________

Phone Number _(______)_________________________

Emergency Contact Name ____

Phone Number _(______)_________________________ Relationship to Patient ______________________

Insurance Carrier ________________________________ Member Number __________________________

Policy Holder Name _____________________________ Policy Holder Date of Birth __________________

67 Broad Street, Suite 200 Charleston, SC 29401
(843) 628-1415
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MEDICAL HISTORY INFORMATION

date: ______________

Patient Name ____ Age ______________

Primary Care Doctor ____

Dermatologist ____

What areas of the face are you interested in improving?

- [ ] Forehead / Brow
- [ ] Eyes
- [ ] Cheeks
- [ ] Jowls / Jawline
- [ ] Neck
- [ ] Chin
- [ ] Nose
- [ ] Ears
- [ ] Skin
- [ ] Wrinkles
- [ ] Other _________________

Do you smoke or use other nicotine products? Yes No
If yes, how much per day? _________________________

Do you drink alcoholic beverages? Yes No
If yes, how much per day? _________________________

List all current medications including vitamins and supplements:

____ ____

____ ____

____ ____

Do you take Aspirin or other blood thinners? Yes No

Have you been treated with Accutane in the past year? Yes No

Have you taken steroids in the past 3 months? Yes No

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List all drug / food / tape allergies:

____ type of reaction __________________________

____ type of reaction __________________________

List all previous surgeries (including cosmetic procedures):

____ ____

____ ____

____ ____

____ ____

Do you or any family members have a history of problems with anesthesia? Yes No

Do you or any family members have a history of any bleeding disorders? Yes No

Have you had a significant weight change in the past year? Yes No
If yes, how many pounds gained or lost? _______________________

Are you currently pregnant or breastfeeding? Yes No

Please check all past and present medical conditions:

CARDIOVASCULAR
- [ ] High blood pressure
- [ ] Heart disease
- [ ] Previous heart attack
- [ ] Murmur
- [ ] Irregular heartbeat
- [ ] Previous stroke
- [ ] Blood clots
- [ ] High cholesterol

PULMONARY
- [ ] Asthma
- [ ] COPD
- [ ] Shortness of breath

NEUROMUSCULAR
- [ ] Muscle weakness
- [ ] Facial paralysis
- [ ] Nerve damage
- [ ] Seizure disorder
- [ ] Spinal / back disorders

PSYCHIATRIC
- [ ] Depression
- [ ] Anxiety
- [ ] Drug or alcohol dependence
- [ ] Psychiatric hospitalization

ENDOCRINE
- [ ] Diabetes
- [ ] Thyroid disease

HEPATIC / RENAL
- [ ] Hepatitis
- [ ] Cirrhosis
- [ ] Kidney disease

GASTROINTESTINAL
- [ ] Acid Reflux
- [ ] Stomach ulcers
- [ ] Constipation or Diarrhea
- [ ] Difficulty swallowing

IMMUNE / INFECTIOUS
- [ ] HIV / AIDS
- [ ] Tuberculosis
- [ ] Lupus
- [ ] Rheumatoid Arthritis
- [ ] Scleroderma
- [ ] Other autoimmune disorders

CANCER
- [ ] Skin cancer
- [ ] Other cancer

EYES
- [ ] Dry eyes
- [ ] Blurred / double vision
- [ ] Cornea problems
- [ ] Glaucoma
- [ ] Thyroid eye disease
- [ ] Wear glasses / contacts

NOSE
- [ ] Nasal allergies
- [ ] Chronic sinus infections
- [ ] Difficulty breathing through nose
- [ ] Decreased sense of smell
- [ ] Previous nasal injury

SKIN
- [ ] Acne
- [ ] Rosacea
- [ ] Eczema
- [ ] Psoriasis
- [ ] Cold sores / herpes
- [ ] Keloids

OTHER ____________________

PHOTOGRAPHY CONSENT

I, ____, hereby give my permission and authorize Dr. David Rodwell or any assistants he may designate to take photographs of me for diagnostic purposes and to enhance the medical record.

I agree that digital and printed copies of these photographs will remain the property of Dr. David Rodwell and Charleston Facial Plastic Surgery, LLC.

I understand that this consent form DOES NOT grant permission to use photographs of me for viewing by other patients or for publication in professional journals, books, magazines, newsletters, or digital formats such as electronic publications or display on the internet without further consent.

By signing below you acknowledge that you have reviewed the policy and agree to these terms.

Patient or Guardian Signature _____________________________________ Date _________________

Printed Name ____

PATIENT INFORMATION AND PRIVACY NOTICE

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

A full copy of the notice of privacy practices is available for your review in print or digital format. The notice describes your rights to access and control of your protected health information.

By signing below you acknowledge that you have reviewed the policy and agree to these terms.

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