



**MOBLEY** MD  
Facial Plastic Surgery

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

What is the best phone number(s) to reach you (i.e. cell phone, pager, etc) \_\_\_\_\_

Do we have your permission to send correspondence to your mailing address? (please circle) YES NO

Do we have your permission to leave detailed phone/voicemail messages? (please circle) YES NO

How did you hear about our practice?

Physician Referral \_\_\_\_\_ Radio \_\_\_\_\_ Internet \_\_\_\_\_ Other \_\_\_\_\_

▣ Why are you here to see Dr. Mobley? (Please circle all that apply)

Nasal Surgery	Treatment of Skin Cancer	Facial Paralysis	Face-lift
Collagen or Restylane	Treatments for facial wrinkles	Eyelid Surgery	Forehead Rejuvenation
Botox	Correction of a facial scar	Protruding Ears	Skin Care or Skin Peel

▣ Do you smoke?

If yes, how much. \_\_\_\_\_

▣ Do you drink alcohol?

If yes, how much \_\_\_\_\_

▣ Occupation: \_\_\_\_\_

▣ List all prescription drugs, especially BLOOD THINNERS, STEROIDS, or ARTHRITIS medications.

▣ List all non-prescription drugs you are currently taking, especially aspirin or NSAIDS (Motrin, Aleve, Excedrin, Ibuprofen). Also include HERBALS, VITAMINS, and HEALTH SUPPLEMENTS

▣ Do you have a Family History of any of the following? (Please circle all that apply)

Cancer	Heart Disease	Anesthesia problems
Diabetes	Poor Wound Healing	Bleeding irregularities

▣ List all ALLERGIES (medications, latex, tape, dyes, etc.)

▣ List ALL previous surgeries – Especially those in the face or neck area:

▣ List any and ALL other medical problems

▣ How do you learn best?

Written Instruction \_\_\_\_\_

Verbal Instruction \_\_\_\_\_

Both \_\_\_\_\_

For Office Use Only

RN Signature \_\_\_\_\_

Patient Review of Systems

**INSTRUCTION:** Please read and check all questions with **YES** or **NO** . Fill in all other information.

**NAME:** \_\_\_\_\_ **HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_  
 (Birth weight if under age 2)

**BIRTHDATE:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**Do you have or have you had any of the following?**

	YES	NO		YES	NO
Rheumatic fever _____			* Blood Transfusions _____		
Heart Murmur _____			* Dentures, caps, loose teeth _____		
High or low blood pressure _____			* Have you had problems in the past with anesthesia? _____		
Chest pain (angina) _____			* Have there been any anesthesia problems in any family members? (Prolonged muscle weakness, hypothermia?) _____		
Heart attack (infarction) _____			* Fevers or Chills _____		
Irregular heart beats _____			* Fatigue _____		
Bleeding /Clotting disorders _____			* Difficulty swallowing _____		
Jaundice or liver disease _____			* Rhinitis or post nasal drip _____		
Hepatitis _____			* Ear, nose, mouth, or throat pain _____		
Anemia or blood problems _____			* Incontinence _____		
Sickle cell anemia _____			Genital or urinary pain _____		
Diabetes _____			Skin rash _____		
Kidney trouble _____			Injection site issues _____		
A recent cold or flu _____			Anxiety _____		
Asthma, bronchitis, emphysema _____			Depression _____		
Tuberculosis _____			Irritability _____		
Do you smoke _____			Hours of sleep each night _____		
<i>Amount in a day</i> _____			Feel constantly tired _____		
<i>Number of years</i> _____			Frequently wake up at night _____		
Shortness of breath _____			How much weight loss or gain in past 6 months _____		
Hiatal Hernia (stomach/throat) _____			Double vision _____		
Infectious mononucleosis _____			Blurry vision _____		
Back or neck trouble _____			Blind spots _____		
Convulsions or epilepsy _____			Dry eyes _____		
Periodic dizziness/fainting _____			Constipation or diarrhea _____		
Stroke _____			Nausea or vomiting _____		
Polio, paralysis, nerve damage _____			Reflux _____		
Thyroid trouble _____			Gastrointestinal pain _____		
Low blood sugar _____			Musculoskeletal aches or pain _____		
Were you a premature baby? _____			Seasonal allergies _____		
AIDS / HIV Positive _____			Frequent illness _____		
Are you an alcohol / drug abuser _____			How often do you exercise _____		
Have you fallen within the last 3 months? _____			When was your last complete physical _____		
Are you allergic to latex? _____			Was anything new diagnosed? _____		
Immunizations out of date? _____					
If female, are you pregnant? _____					
List first day of last period _____					

\_\_\_\_\_  
**Patient/Guardian Signature** **Date**

\_\_\_\_\_  
**RN/MA Signature** **Date**

\_\_\_\_\_  
**MD Signature (after review)** **Date**