THE LANFRANCHI CENTER
Facial Plastic Surgery & Rejuvenation

Medical History

Patient Name: _____ Today's Date: _____/_____/_____

Personal Medical History

Is walking up a flight of stairs with a bag of groceries difficult for you?	☐ Yes	☐ No
Are you currently pregnant?	☐ Yes	☐ No
Have you had radiation therapy or chemotherapy for cancer?	☐ Yes	☐ No
Have you had Lupus, Rheumatoid Arthritis, Sarcoidosis, Scleroderma, Wegener's Disease, or Ehlers Danlos Syndrome?	☐ Yes	☐ No
Have you had surgery of the face or neck within the previous 6 months?	☐ Yes	☐ No
Oxygen dependent COPD or severe asthma?	☐ Yes	☐ No
Bleeding disorder?	☐ Yes	☐ No
Abnormal scarring?	☐ Yes	☐ No
Reaction to Latex?	☐ Yes	☐ No
Lidocaine allergy?	☐ Yes	☐ No
Epinephrine sensitivity?	☐ Yes	☐ No
Currently taking Aspirin, Coumadin, Plavix, Pradaxa or other Anticoagulant (Blood Thinner)?	☐ Yes	☐ No
Brain Aneurysm or Brain Shunt?	☐ Yes	☐ No
Prior Parotidectomy (Salivary gland removal)?	☐ Yes	☐ No
Obstructive sleep apnea?	☐ Yes	☐ No
Do you have Restless Leg Syndrome?	☐ Yes	☐ No
HIV/ AIDS?	☐ Yes	☐ No
Narcotic Use or Dependency?	☐ Yes	☐ No
Do you consume more than 2 alcoholic drinks per day on average?	☐ Yes	☐ No
Current smoker? Amount?	☐ Yes	☐ No

Kidney Insufficiency?	☐ Yes	☐ No
Liver Insufficiency, Cirrhosis, Hepatitis, or Hep C?	☐ Yes	☐ No
Blood Clots or Pulmonary Embolism?	☐ Yes	☐ No
History or symptoms of Tuberculosis (i.e. productive cough, bloody sputum, fever)?	☐ Yes	☐ No
Diabetes that requires medication?	☐ Yes	☐ No
Heart disease or problems?	☐ Yes	☐ No
Angina or Chest Pain with exercise?	☐ Yes	☐ No
Angioplasty and/or Stent Placement?	☐ Yes	☐ No
Have you ever had a Heart Attack?	☐ Yes	☐ No
Do you have a Pacemaker or Defibrillator?	☐ Yes	☐ No
Heart Catheterization/ Stress Test? Date:_____ ☐ Normal ☐ Abnormal	☐ Yes	☐ No
Have you ever had Stroke or TIA?	☐ Yes	☐ No
Severe Dry Eyes?	☐ Yes	☐ No
Limited Neck Mobility?	☐ Yes	☐ No
Have you used the medication Accutane within the last year?	☐ Yes	☐ No

If you answered "yes" to any of the above, please provide details below, and indicate the name of the specialist physician that is treating this condition, as well as the last time that you saw this physician. Please also list anything Dr. Lanfranchi should know about your medical health or any special concerns. Please include recent illnesses that required hospitalization, recent contact with your physician, or new medications or antibiotics.

_____

_____

Physician: _____ Phone #: _____ Date of Last Exam: _____

Cardiologist Name (if applicable): _____ Phone #: _____ Date of Last Exam: _____

May we contact your physician(s) in order to obtain medical clearance if necessary? ☐ Yes ☐ No

Pharmacy (& Location): _____ Phone Number: _____

Additional History

Please list any previous surgeries/dates	Non- surgical procedures/dates (i.e. Botox, and/or Fillers)

List ALL medications or supplements (prescribed and non-prescribed) you are currently taking: **Check here if none** ☐

Medication(s):	**Dosage & Frequency:**

Please list any medications that you are allergic to and describe the reaction, if any. **Check here if none** ☐

Medication allergy:	**Type of Reaction:**

I certify that I have listed all of my medical conditions, allergies, hospitalizations, and previous surgeries and current medications/supplements to the best of my knowledge and ability.

Signature: _____ Date: _____

Emergency Contact (Name/ Phone): _____