**DAVID L.J. WARDLE, M.D., F.R.C.S.(C)**
Fellow, Royal College of Physicians and Surgeons
Aesthetic, Plastic and Reconstructive Surgery

360 SAN MIGUEL DRIVE SUITE 406
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# NEW PATIENT INFORMATION

Today's Date_____________________________ Marital Status______________________

Name: ____________________________________ Birthdate:___/___/___ Age:_______________

Address: ______________________________________________________________ Sex: M / F

City: ____________________________________________ State: _________ Zip Code: ___________

Home: (___)________________ Cell: (___) ___________________ Work: (___) _________________

**EMAIL**: __________________________________________

Emergency Contact: ____________________________________ Telephone: (___) _________________

How did you hear about Dr. Wardle? _______________________________________________________

Employer: _______________________________________ Occupation: ___________________________

Please put a check mark next to the procedures about which you would like to receive more information:

**Facial Therapies:**
_____Botox and/or Dysport to lessen Wrinkles
_____Juvederm, Perlane, Restylane Fillers
_____Skin Care / TCA Skin Peels
_____Lip Augmentation
_____Facial Rejuvenation

**Laser Treatments:**
_____Hair Removal
_____Brown Spots
_____Facial Redness
_____Spider Veins/Leg Veins
_____Broken Capillaries

**Please list any current Medical Conditions**:

_______________________________________________________________________________________

_______________________________________________________________________________________

**Please list any Medications or Herbal Supplements that you are currently taking**:

_______________________________________________________________________________________

_______________________________________________________________________________________

_________________________________________________ ____________________
Patient Signature Date

# PATIENT HEALTH QUESTIONAIRE

1. Do you have **allergic reactions** to any medications? ________________________________________________________
2. Do you react abnormally to any medication or anesthesia? Yes No If so, which? __________________________________
3. Do you have any **family history** of cancer, heart trouble, stroke, malignant hyperthermia?__________________________
   If so, which family member(s)? __________________________________________________________________________
4. Do you have **cocktails** regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol? _________________________If so, how much? ____________________________________
5. Do you **smoke**? Yes No If so, how much? ______________________________________________________________
6. Do you have a history of **excessive bruising or bleeding** following surgery or minor trauma (including tooth extractions or mouth trauma)? Yes No
7. Have you, or your blood relatives required blood transfusions following previous surgery or trauma?
   Yes No If so, please specify: ________________________________________________________________
8. Are you **pregnant**? Yes No When was your last menstrual period? ____/____/____
9. Was it normal? Yes No
10. How many pregnancies? ________ Births: _______ Breast fed? _______ How long? ________
11. Have you ever been on Cortisone or Steroid treatment? Yes No If so, when? __________________________________
12. Please list **all present medications**, including Birth Control Pills, hormones, vitamins and over the counter medications:

    ______________________________________________________________________________________________

    ______________________________________________________________________________________________
13. Do you take Diuretics? Yes No If so, what? __________________________________________________________
14. When was your last Physical Exam? _____/______/_____ By whom? Dr. ______________________________________
15. When was your last Eye Exam? _____/____/_____ By whom? Dr. ______________________________________
16. When was your last Electrocardiogram (EKG) and where? _________________________________________________
17. When was your last Chest X-Ray and where? ____________________________________________________________

18. Please list **all** prior Hospitalizations and Surgical Operations, including date and reason:

**HOSPITALIZATIONS:**

| Where: | When: | Why: |
|---|---|---|
| | | |
| | | |
| | | |

**SURGICAL OPERATIONS:**

| What: | When: | Doctor: |
|---|---|---|
| | | |
| | | |
| | | |

**DRUG HISTORY: TAKEN IN LAST 6 MONTHS:**

_____STEROIDS (CORTISONE, ACTH, ETC)
_____ANTIBIOTICS
_____DIABETIC MEDICATION
_____THYROID MEDICATION
_____ARTHRITIS MEDICATION
_____TRANQUILIZERS
_____NARCOTICS
_____BLOOD PRESSURE MEDICATION
_____HEART MEDICATION
_____DIET PILLS ___________________________

Patient's Signature____________________________________________________Date:___________________________

## PATIENT HEALTH QUESTIONAIRE

Name: ________________________________________ Age: ______ Marital Status: _____ Date: ____/____/____
Height: _____________________ Weight ___________ lbs.
General Health is? ___________________________Have you had a cold or flu in the past month? _____________
If so, which? __________________ When? ________________ Are symptoms still present? ______________
Race (ethnic) Background is: ______________________________________________________________

**HAVE YOU EVER HAD OR BEEN TOLD THAT YOU HAD ANY OF THE FOLLOWING CONDITIONS:**

| Condition | | | Condition | | |
|---|---|---|---|---|---|
| Heart Trouble/Congestive Heart Failure | yes | no | Glaucoma or Eye Disorder | yes | no |
| Heat Attack/Heart Pain | yes | no | Visual disturbances | yes | no |
| Endocarditis | yes | no | Error in Refraction | yes | no |
| Palpitation or Irregular pulse | yes | no | Other Eye Problems | yes | no |
| Extra Heart Beat | yes | no | Hepatitis A | yes | no |
| Mitral Valve Prolapse | yes | no | Hepatitis B or C | yes | no |
| Stroke or TIA (Transient Ischemic Attack) | yes | no | Yellow Jaundice | yes | no |
| Blood Disease | yes | no | Gallstones or Gallbladder Trouble | yes | no |
| High Blood Pressure | yes | no | Cirrhosis of the Liver | yes | no |
| Abnormal Electrocardiogram (EKG) | yes | no | Alcoholism | yes | no |
| Rheumatic Fever | yes | no | Esophageal Varices | yes | no |
| Dropsy or Heart Failure | yes | no | Frequent Indigestion | yes | no |
| Digitalis Treatment | yes | no | Ulcers | yes | no |
| Shortness of Breath | yes | no | Gastritis | yes | no |
| Chest Pain | yes | no | Colitis/Crohn's Disease | yes | no |
| Asthma | yes | no | Problem Constipation | yes | no |
| Bronchitis | yes | no | Vomiting Blood | yes | no |
| Tuberculosis | yes | no | Tarry / Bloody Bowel Movements | yes | no |
| Pneumonia | yes | no | Hemorrhoids | yes | no |
| Smoker's Cough | yes | no | Thyroid Disorder | yes | no |
| Coughing or Spitting of Blood | yes | no | Skin Disorder | yes | no |
| Hay Fever | yes | no | Arthritis | yes | no |
| Major Allergies | yes | no | Fracture of Neck or Spine | yes | no |
| Frequent Respiratory Infections | yes | no | Bleeding Tendency or Disorder | yes | no |
| Nervous Breakdown | yes | no | Abnormal Bleeding after Tooth Extraction | yes | no |
| Nervous Disorder | yes | no | Airway Obstruction (Nasal) | yes | no |
| Insomnia | yes | no | Breast Cysts, Tumors, Abscesses | yes | no |
| Drug Addiction/Habit | yes | no | Nipple Discharge (Abnormal Lactation) | yes | no |
| Self-Destructive Tendencies | yes | no | Kidney / Bladder Problems | yes | no |
| Psychiatric Hospitalization or Care | yes | no | Blood Transfusion | yes | no |
| AIDS or HIV Infection | yes | no | Blood Infection | yes | no |
| Herpes | yes | no | Seizures / Seizure Disorder | yes | no |
| Cancer | yes | no | Abnormal Reaction to Anesthetics | yes | no |
| Diabetes | yes | no | Malignant Hyperthermia | yes | no |

Patient Signature__________________________________________________Date___/___/___