CARNIOL
PLASTIC SURGERY

COSMETIC • LASER • RECONSTRUCTIVE

Name: _____ Today's date: _____

How did you hear about us? _____

E-mail address for special offers: _____

Are you under a doctor's care for any condition? If so, please list:

_____

_____

Do you have:

	Yes	No			Yes	No	
Diabetes (*Circle*: **Type 1 / Type 2**)	☐	☐	_____	**Immune deficiency**	☐	☐	_____
High blood pressure	☐	☐	_____	**Autoimmune disease**	☐	☐	_____
Thyroid problems	☐	☐	_____	**Kidney and/or bladder problems**	☐	☐	_____
Hormone problems	☐	☐	_____	**Neurological problems**	☐	☐	_____
Heart problems	☐	☐	_____	**Psychological/emotional problems**	☐	☐	_____
Mitral valve problems	☐	☐	_____	**Cancer**	☐	☐	_____
Breathing problems (such as asthma)	☐	☐	_____	**Other Problems**	☐	☐	_____
Bleeding problems	☐	☐	_____				
Skin conditions	☐	☐	_____				
Fever blisters/cold sores/herpes	☐	☐	_____				

Previous Surgery:

_____

_____

Have you ever been on Accutane Circle: Yes ☐ No ☐

Social History:	Yes	No	Please list details below:
Do you use tobacco?	☐	☐	List type and how much: _____
If no, did you use it previously?	☐	☐	List type and how much: _____ When did you quit? _____
Do you drink alcohol?	☐	☐	List type and how much: _____
Do you use recreational drugs?	☐	☐	List type and how much: _____