Savannah
FACIAL PLASTIC SURGERY
TIMOTHY MINTON MD, FACS

5356 REYNOLDS STREET, SUITE 510 · SAVANNAH, GA 31405
912.644.0744 · 912.644.0757 FAX
WWW.SAVANNAHFACIALPLASTICSURGERY.COM

Patient Account Number _____

Date: _____ Patient Name: _____ Height:_____ Weight_____

Referred By: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ Phone (Work): _____ Phone (Cell): _____

Date of Birth: _____ Age: _____ Occupation: _____ Marital Status _____

Email: _____ ☐ Yes, I would like to receive emails about specials, deals and practice updates.

Emergency Contact: _____ Phone: _____ Relationship: _____

Family Physician: _____ Phone: _____ City/State: _____

Please check what you are interested in:

☐ Basic Skin Care (Facial)	☐ Nose Surgery	☐ Removal of brown spots, red spots	☐ Chemical Peels
☐ Specialized Facial	☐ Eyelid or Eyebrow Surgery	☐ Filler Injections	☐ Other _____
☐ Facelift	☐ Rosacea Treatment	☐ Botox	

MEDICAL PROBLEMS AND PAST SURGERIES:

_____

_____

_____

MEDICATIONS: Are you taking ANY medications or drugs? If so, list below:

_____

_____

☐ Yes ☐ No Vitamins or Herbal Supplements_____

☐ Yes ☐ No Have you taken any products containing Aspirin or blood thinners in the last 7 days? _____

☐ Yes ☐ No Are you allergic to any medications? Please list: _____

☐ Yes ☐ No Facial injections? If so, when? _____

☐ Yes ☐ No Recent facial surgery? If so, when? _____

☐ Yes ☐ No Laser resurfacing?

☐ Yes ☐ No Previous chemical peel – if so, what type? _____ When? _____

☐ Yes ☐ No Do you use glycolic or alphahydroxy skin care products?

☐ Yes ☐ No Have any skin care or makeup products caused any skin problems?

☐ Yes ☐ No Do you wear sunblock daily?

☐ Yes ☐ No Are you pregnant, nursing or planning a pregnancy?

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☐ Yes ☐ No Have you taken Accutane (Isotretinoin). If yes, when? _____

☐ Yes ☐ No Do you get cold sores?

Please list all products you are using on your skin including soaps, prescription topicals, creams, scrubs, etc.

_____

_____

_____

What brand of makeup do you use? _____

Your skin type is? (please circle one) Normal Dry / Dehydrated Oily Acne / Acne prone Rosacea

When were you last exposed to sun or a tanning bed?_____

Are you currently using or have you used Retin A? ☐ Yes ☐ No

If yes, what strength of Retin A have you used? ☐ .025 % ☐ .05% ☐ .1%

How long have you been using Retin A? _____

Are you undergoing any facial waxing procedures? ☐Yes ☐ No If yes, what area? _____

Have you experienced any of the following?

High or low blood pressure ..... ☐ Yes ☐ No
Seizures or convulsions ..... ☐ Yes ☐ No
Stroke..... ☐ Yes ☐ No
Asthma..... ☐ Yes ☐ No
Pulmonary embolus..... ☐ Yes ☐ No
Septicemia..... ☐ Yes ☐ No
Hepatitis..... ☐ Yes ☐ No
Easily Bruise..... ☐ Yes ☐ No
Migraine Headaches..... ☐ Yes ☐ No
Dark spots after pregnancy or injury..... ☐ Yes ☐ No
Cancer..... ☐ Yes ☐ No
Scleroderma..... ☐ Yes ☐ No
Keloid scars..... ☐ Yes ☐ No
Treatment with Coumadin or Heparin..... ☐ Yes ☐ No
Hormone replacement therapy..... ☐ Yes ☐ No
Circulatory problems..... ☐ Yes ☐ No
Tumors or cysts..... ☐ Yes ☐ No
Cataracts / dry eye..... ☐ Yes ☐ No
Eye or eyelid surgery..... ☐ Yes ☐ No
Visual disturbances..... ☐Yes ☐ No
Depression / Severe mood swings..... ☐ Yes ☐ No

Diabetes..... ☐ Yes ☐ No
Fainting or Dizzy Spells..... ☐ Yes ☐ No
Blood transfusion..... ☐ Yes ☐ No
Thrombophlebitis..... ☐ Yes ☐ No
Deep vein thrombosis..... ☐ Yes ☐ No
Autoimmune disease (lupus, MS)..... ☐ Yes ☐ No
Hemophilia/bleeding disease..... ☐ Yes ☐ No
Heart Disease..... ☐ Yes ☐ No
Immunodeficiency condition..... ☐ Yes ☐ No
Rheumatoid arthritis..... ☐ Yes ☐ No
Skin Cancer..... ☐ Yes ☐ No
Cold sores/herpes simplex..... ☐ Yes ☐ No
Abnormal response to light..... ☐ Yes ☐ No
Treatment with Accutane..... ☐ Yes ☐ No
Abnormal heart condition..... ☐ Yes ☐ No
Epilepsy..... ☐ Yes ☐ No
Chemotherapy or radiation..... ☐ Yes ☐ No
Corneal abrasions..... ☐ Yes ☐ No
Contacts..... ☐ Yes ☐ No
Other _____

Patient's Signature _____ Date: _____

Physician's Signature _____ Date: _____