CHARLESTON
Facial Plastic Surgery
DAVID RODWELL, MD

PATIENT INFORMATION

date: _____

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Cell Phone _(_____)_____ Home Phone _(_____)_____

Email _____ May we contact you by email? Yes No

Date of Birth _____ Age _____ Marital Status _____

Patient's Occupation _____

Who referred you to our office? _____

Spouse or Parent's Name _____

Phone Number _(_____)_____

Emergency Contact Name O (check if same as above)

_____

Phone Number _(_____)_____ Relationship to Patient _____

67 Broad Street, Suite 200 Charleston, SC 29401
(843) 628-1415
CharlestonFacialPlastic.com

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Facial Plastic Surgery
DAVID RODWELL, MD

MEDICAL HISTORY INFORMATION

date: _____

Patient Name _____ Age _____

Primary Care Doctor _____

Dermatologist _____

What areas of the face are you interested in improving?

- ☐ Forehead / Brow
- ☐ Eyes
- ☐ Cheeks
- ☐ Jowls / Jawline
- ☐ Neck
- ☐ Chin
- ☐ Nose
- ☐ Ears
- ☐ Skin
- ☐ Wrinkles
- ☐ Other _____

Do you smoke or use other nicotine products? Yes No
If yes, how much per day? _____

Do you drink alcoholic beverages? Yes No
If yes, how much per day? _____

List all current medications including vitamins and supplements:

_____ _____

_____ _____

_____ _____

_____ _____

Do you take Aspirin or other blood thinners? Yes No

Have you been treated with Accutane in the past year? Yes No

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List all drug / food / tape allergies:

_____ type of reaction _____

_____ type of reaction _____

List all previous surgeries (including cosmetic procedures):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you or any family members have a history of problems with anesthesia? Yes No

Do you or any family members have a history of any bleeding disorders? Yes No

Have you had a significant weight change in the past year? Yes No
If yes, how many pounds gained or lost? _____

Are you currently pregnant or breastfeeding? Yes No

Please check all past and present medical conditions:

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Previous heart attack
- ☐ Murmur
- ☐ Irregular heartbeat
- ☐ Previous stroke
- ☐ Blood clots
- ☐ High cholesterol

PULMONARY
- ☐ Asthma
- ☐ COPD
- ☐ Shortness of breath

NEUROMUSCULAR
- ☐ Muscle weakness
- ☐ Facial paralysis
- ☐ Nerve damage
- ☐ Seizure disorder
- ☐ Spinal / back disorders

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Drug or alcohol dependence
- ☐ Psychiatric hospitalization

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid disease

HEPATIC / RENAL
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Kidney disease

GASTROINTESTINAL
- ☐ Acid Reflux
- ☐ Stomach ulcers
- ☐ Constipation or Diarrhea
- ☐ Difficulty swallowing

IMMUNE / INFECTIOUS
- ☐ HIV / AIDS
- ☐ Tuberculosis
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma
- ☐ Other autoimmune disorders

CANCER
- ☐ Skin cancer
- ☐ Other cancer

EYES
- ☐ Dry eyes
- ☐ Blurred / double vision
- ☐ Cornea problems
- ☐ Glaucoma
- ☐ Thyroid eye disease
- ☐ Wear glasses / contacts

NOSE
- ☐ Nasal allergies
- ☐ Chronic sinus infections
- ☐ Difficulty breathing through nose
- ☐ Decreased sense of smell
- ☐ Previous nasal injury

SKIN
- ☐ Acne
- ☐ Rosacea
- ☐ Eczema
- ☐ Psoriasis
- ☐ Cold sores / herpes
- ☐ Keloids

OTHER _____

PHOTOGRAPHY CONSENT

I, _____, hereby give my permission and authorize Dr. David Rodwell or any assistants he may designate to take photographs of me for diagnostic purposes and to enhance the medical record.

I agree that digital and printed copies of these photographs will remain the property of Dr. David Rodwell and Charleston Facial Plastic Surgery, LLC.

I understand that this consent form DOES NOT grant permission to use photographs of me for viewing by other patients or for publication in professional journals, books, magazines, newsletters, or digital formats such as electronic publications or display on the internet without further consent. These photos are for the medical record only.

By signing below you acknowledge that you have reviewed the policy and agree to these terms.

Patient or Guardian Signature _____ Date _____

Printed Name _____

PATIENT INFORMATION AND PRIVACY NOTICE

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

A full copy of the notice of privacy practices is available for your review in print or digital format. The notice describes your rights to access and control of your protected health information.

By signing below you acknowledge that you have reviewed the policy and agree to these terms.

Patient or Guardian Signature _____ Date _____

Printed Name _____