Dr. Edward Szachowicz MD PhD - Facial Plastic Surgery

New Patient Welcome Form

Welcome!

We look forward to having you as a new client at Facial Plastic Surgery. The general information and medical history requested below will help Dr. Szachowicz gain a better understanding of your particular concerns, as well as serving as a guide in customizing recommendations for you. Please bring this information with you to your consultation with Dr. Szachowicz, along with any other information you may want the doctor to know. Clients interested in options for rejuvenation of the face are encouraged to bring in photographs of them, at a younger age.

Name_____
First Middle Initial Last

Address_____
Street & Apt. # City State Zip

Home Phone_____ Cell_____ Other_____

Age_____ Birthdate_____ Sex: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married to: _____ ☐ Other _____

Occupation_____ Employer _____

Work Phone _____Ext._____ Is it okay to call you at work? ☐ Yes ☐ No

Emergency Contact:_____ Relationship to you_____

Primary Physician or Clinic: _____

May we communicate with your primary care /referring physician about your care? ☐ No ☐ Yes

How did you hear about Dr. Szachowicz? Please check all that apply.

- ☐ Facial Plastic Surgery Website
- ☐ Office Newsletter
- ☐ Top Doctor Website for Mpls/StPaul magazine
- ☐ Mpls/StPaul magazine
- ☐ Minnesota Monthly magazine
- ☐ Friend / Relative: _____
- ☐ Doctor / Nurse: _____
- ☐ Spa / Salon: _____
- ☐ Other: _____
- ☐ Edina Chamber of Commerce
- ☐ RealSelf
- ☐ Youtube
- ☐ TV News
- ☐ Facebook

Please answer the following:

(1) What concerns would you like to discuss during your consultation? What are your goals?

(2) What has to happen for your consultation to be successful? What is most important for you?

(3) Is there anything that may have an impact on you being treated by Dr. Szachowicz that he needs to know? Anything else you want Dr. Szachowicz to know?

(4) How long have you been thinking about this?

(5) Do you have an important event coming up?

(6) Have you had a cosmetic consultation or cosmetic treatment before?

(7) Do you have a budget in mind?

(8) What is your sun exposure history?

(9) Please describe your ethnic background (for skin typing and laser compatibility):

(10) Do you have medication or latex allergies? ☐ No
☐ Yes: _____

(11) Do you have any significant past or current medical illnesses (including high blood pressure)? ☐ No
☐ Yes: _____

(12) Do you smoke or have you ever smoked? ☐ No ☐ Yes: _____packs/day, _____ years

(13) Are you HIV positive or do you have AIDS? ☐ No ☐ Yes
(14) Do you have hepatitis or have you been exposed to hepatitis? ☐ No ☐ Yes
(15) Have you been treated for skin problems? ☐ No ☐ Yes
(16) Have you been treated with Accutane, facial irradiation, or electrolysis? ☐ No ☐ Yes
(17) Do you form thick or raised scarring from a cut or burn? ☐ No ☐ Yes

For women:
(18) Are you pregnant or are you currently breast feeding? ☐ No ☐ Yes
(19) Are you on oral contraceptives? ☐ No ☐ Yes
(20) During pregnancy, did you ever get hyperpigmentation or a facial mask? ☐ No ☐ Yes
(21) Do you have regular periods? ☐ No ☐ Yes
(22) Are you going through menopause? ☐ No ☐ Yes

I affirm that the above information is accurate.

_____ _____
Signature Date