DR. GRUNWALDT FALBO
PLASTIC SURGERY & MEDSPA

Name:_____ **Date of Birth:**_____ **Age:**_____

Email address:_____ **Phone Number:**_____

Emergency Contact:_____

Past Medical History:_____

_____

Past Surgical History:_____

_____

_____

Medications:_____

_____

Allergies to medicines (if yes, list): _____

Social History:

Type of work:_____

Nicotine products circle: cigarettes, cigars, pipe, vape

Alcohol:_____

Review of Systems (circle if yes):

General: fever, fatigue or loss of appetite

Eyes: eye pain or discharge

Ears, Nose, Mouth, Throat: ear pain, sore throat or nasal congestion.

Gastrointestinal: abdominal pain, vomiting, or diarrhea

Cardiovascular: history of murmur or heart problem

Respiratory: cough, wheeze or shortness of breath

Hematology/Lymph: unusual bruising, bleeding, or blood clots

Endocrine/Metabolic: excessive urination, excessive thirst, hair thinning, unexplained weight gain/loss

Musculoskeletal: muscles aches, joint aches, unusual swelling

Neurologic: headache, visual changes

Specific History with Fillers and Neurotoxins (eg Botox, Juveaux, Dysport, Xeomin)

- Have you ever had a filler or neurotoxin used in your face? Yes / No

  If yes, please list what and when: _____

- Have you ever had an allergic reaction to a filler or neurotoxin? Yes / No

  If Yes, please list reaction: _____

- Have you ever been diagnosed with an autoimmune problem? Circle any that apply or list others:

  Systemic Lupus erythematosus (SLE or lupus)

  Rheumatoid arthritis

  Multiple sclerosis

  ALS (Lou Gehrig's Disease)

  Type 1 diabetes

  Guillain-Barre

  Psoriasis

  Myasthenia gravis

  Progressive muscle weakness

  Other: _____

- Any chance you could be pregnant? Yes / No

- Any history of cold sores in and around the mouth: Yes / No

- Any recent infections in your face or sinuses? Yes / No

- Any recent use of blood thinners? Yes / No

  If yes, please list: _____