THOMAS FUNCIK, MD

Coastal Facial Plastic Surgery

Historical Data Sheet

Patient's Name: ____ Date: ____________________

Which procedure(s) are you interested in?

____ Charleston Custom Lift®
____ Lowcountry Lid Lift®
____ Cosmetic Rhinoplasty (Nose)
____ Forehead lift
____ Otoplasty (Ears)
____ Chin Augmentation
____ Cheek Augmentation
____ Fat transfer
____ Oral Commissuroplasty
____ Removal of facial sun spots (hyperpigmentation)
____ Dysport®/Botox®
____ Restylane®/Juvederm®/Belotero®
____ Perlane®
____ Sculptra Aesthetic®
____ Scar Revision
____ Removal of cyst, mole, skin cancer etc.
____ Parisian Peel
____ VI Chemical Peel
____ Rejuvapen ®
____ Other ______________________________

Have you consulted with another doctor in regards to this type of procedure Yes No
Have you had any previous cosmetic surgery? Yes No
If yes, please state what type of procedure ________________________and when performed __________
Who performed the surgery? ____

Medical History

When was your last physical examination? ____
Who is your Internist/Family Doctor? ____
Who is your OBGYN? ________ N/A ____
List allergies to any medications and reactions: _______________________________________
____
____
Have you had any reaction to local or general anesthesia? __________________________________
Explain: ____
Are you taking any over the counter or prescription medications? Yes ________ No __________
List names and Dosage: ____
____
____
Do you take Vitamins or supplements regularly? ____
List them: ____
Are you pregnant at present or trying to conceive? _____ N/A ____________________________________
When was your last menstrual cycle? ____
Have you ever taken Accutane (for acne)? ____
Do you take Aspirin, Advil, Motrin, or any other blood thinners? _____________________________
Do you have a history of bleeding or excessive bruising? ____
Have you ever had herpes, fever blisters, or cold sores? ____
Have you ever had surgery or injuries to or around the face, neck or eyes? __________________
If so, when ________________________ Describe injury ____
Have you or any member of your household had an infection with MRSA? ________________________

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Have you or any member of your immediate family been affected by any of the following condition?
√ boxes and identify who by relationship:

_____ Heart trouble ________________________________
_____ High blood pressure___________________________
_____ Diabetes _____________________________________
_____ Bleeding _____________________________________
_____ Poor Healing _________________________________
_____ Psychiatric problems __________________________
_____ Nervous problems _____________________________
_____ Thyroid ______________________________________
_____ Arthritis _____________________________________
Excessive bruising ___________________________
Excessive scaring ____________________________
Tuberculosis _________________________________
Other _______________________________________

Have you ever had any surgeries we should be aware of? √ boxes, give dates, and specifics regarding type:
____
____
____

Were there any complications to any of the above mentioned procedures _________________________
____

Number of pregnancies _________________________ Number of deliveries _________________________
Ages of each child: ____

No	Yes	Do you have hay fever, asthma, or allergies?
No	Yes	Do you have chest pains with stress or exertion?
No	Yes	Do you have stomach trouble or ulcers?
No	Yes	Have you ever had liver, gallbladder trouble, or yellow jaundice? (circle one)
No	Yes	Do you have skin irritations, rashes or sensitivity to adhesive tape?
No	Yes	Do you have headaches or dizzy spells?
No	Yes	Has any part of your body ever been paralyzed?
No	Yes	Do you ever have convulsion or seizures?
No	Yes	Have you ever had loss of vision?
No	Yes	Do you have dry eyes?
No	Yes	Do you suffer with blurred vision?
No	Yes	Are you being treated for glaucoma?
No	Yes	Were you ever treated for anemia?
No	Yes	Have you ever been treated for a venereal disease?
No	Yes	Have you ever taken hormones or thyroid medication?
No	Yes	Do you smoke?_____ per day ______ how long
No	Yes	Do you drink more then 3 cups of coffee a day?
No	Yes	Do you usually drink two or more alcoholic beverages per day?
No	Yes	Do you often get depressed?
No	Yes	Have you ever had a nervous breakdown or panic attack?
No	Yes	Have you ever received medical attention for a nervous condition?
No	Yes	Are you fearful of doctors or dentists?
No	Yes	Do you have any medical problems that have not been covered?
No	Yes	Are there any private medical conditions such as drug use, HIV infection, etc. That you would like to discuss with Dr. Funcik privately?

Signature: ____ Date: ___________________________