# Dr. Jaclyn A Klimczak, MD

Facial Plastic Surgery

## Consultation Form

**In which procedure are you interested in today:**

| | | |
|---|---|---|
| ☐ Face/neck rejuvenation | ☐ Rhinoplasty | ☐ Eyelids |
| ☐ Septoplasty | ☐ Scar Revision | ☐ Facial Reconstruction |
| ☐ Brows | ☐ Botox Injection | ☐ Skin Resurfacing |
| ☐ Removal of Cysts, Moles, etc | ☐ Fillers | ☐ Hair Restoration |
| ☐ Protruding ears | ☐ Other: _____ | |

When did you begin to consider surgical correction:_____

Why have you decided to have it done at this point in time:_____

Have you consulted any other doctor about this: **Yes:**☐ **No:**☐ When?_____

Have you discussed surgery with your family: **Yes:**☐ **No:**☐ Are they agreeable? **Yes:**☐ **No:**☐

Why have you decided to have it done at this point in time:_____

Have you consulted any other doctor about this: **Yes:**☐ **No:**☐ When?_____

Have you had previous cosmetic, plastic or reconstructive surgery: **Yes:**☐ **No:**☐ When and what if anything was done?

_____

Who performed the surgery:_____ Where?_____ Satisfied with the results? **Yes:**☐ **No:**☐

If not why:_____

If injury describe?_____

Date of injury:_____ Place of injury:_____ Treatment received:_____

Do you have problems breathing through your nose: **Yes:**☐ **No:**☐ Do you have sinus problems: **Yes:**☐ **No:**☐

Have you had Nasal Trauma? **Yes:**☐ **No:**☐ When?_____ Describe:_____

Has anyone in your family or a close friend had cosmetic, plastic or reconstructive surgery? **Yes:** **No:**

What was done?_____ By whom?_____

Have you had any other prior surgery? **Yes:**☐ **No:**☐ What/When was it performed?

Head and neck:_____ Skin:_____ Teeth/Gums:_____

Reproductive system:_____ Back/Arms/Legs:_____ Chest:_____

Abdomen_____ Other:_____

Did you have a normal recovery: **Yes:**☐ **No:**☐ If not explain:_____

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Who is your primary physician:_____Telephone:_____

Address:_____City:_____State: _____

May we have permission to consult with your physician: **Yes:**☐**No:**☐

**Yes:**☐**No:**☐Are you taking any drugs or medications? List them if you can:_____

_____

**Yes:**☐**No:**☐Are you allergic to any medications, cream, tape, makeup etc? _____

**Yes:**☐**No:**☐Have you ever received local anesthesia? (“Novacaine, Xylocaine?)

**Yes:**☐**No:**☐Did you have a reaction to any anesthesia? Explain_____

**Yes:**☐**No:**☐Do you have any family members who have the following: List Who/What

Heart trouble☐_____Excessive bleeding tendencies☐_____

High Blood pressure☐_____Diabetes☐_____Thyroid issues☐_____

Psychiatric/nerve problems☐_____Excessive bruising/scarring☐_____

Delayed or poor healing☐_____Other☐_____

**Yes:**☐**No:**☐Do you have a history of bleeding? (indicate which)

From the nose☐ In the Urine☐ Vomiting Blood☐ From the rectum☐

Coughing up blood☐ Other☐

**Yes:**☐**No:**☐Do you have/had nasal allergies, sinus issues, asthma or hay fevers? Explain_____

**Yes:**☐**No:**☐Do you have/ had any problems with your eyes or vision? Explain_____

**Yes:**☐**No:**☐Has a doctor ever said you have “heart trouble?” Explain_____

**Yes:**☐**No:**☐Do you have stomach trouble or ulcers? Explain_____

**Yes:**☐**No:**☐Do you have/had chest or lung problems? Explain_____

**Yes:**☐**No:**☐Have you ever had liver, gallbladder issues or jaundice? Explain_____

**Yes:**☐**No:**☐Have you been bothered by kidney or bladder problems? Explain_____

**Yes:**☐**No:**☐Have you ever had fever blisters, cold sores, canker sores on your face? Explain_____

**Yes:**☐**No:**☐Do you often have severe headaches or dizzy spells? Explain_____

**Yes:**☐**No:**☐Has any part of your body every been paralyzed/number? Explain_____

**Yes:**☐**No:**☐Did you ever have a convulsion or seizure? Explain_____

**Yes:**☐**No:**☐Were you ever told you had any venereal disease or HIV/AIDS? Explain_____

**Yes:**☐**No:**☐Were you ever treated for anemia or any problems with your blood? Explain_____

**Yes:**☐**No:**☐Have you ever taken hormones or thyroid mediation? Explain _____

**Yes:**☐**No:**☐Do you smoke? If so, how much/how long_____

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**Yes:**☐ **No:**☐ Do you drink two or more alcoholic drinks/day?

**Yes:**☐ **No:**☐ Do you often get depressed?

**Yes:**☐ **No:**☐ Have you ever received medical treatment for depression/anxiety? Explain_____

**Yes:**☐ **No:**☐ Have you ever been under the care of a psychiatrist or psychologist? Explain_____

_____

**Yes:**☐ **No:**☐ Do you have any other medical problems that have not been covered? Explain_____

_____

**Yes:**☐ **No:**☐ Do you accept the fact that every medical and surgical treatment is associated with risks and imponderables?

**Yes:**☐ **No:**☐ Do you have an advanced directive?

**Patient name:**_____ **Relationship to patient:**_____

**Patient Signature:**_____ **Date:**_____ **Time:**_____

**Reviewed by Physician:** _____ **Date:**_____ **Time:**_____