Ekcott MD
Facial Plastic Surgery

1030 E. Foothill Blvd., Ste. 101, Upland, CA 91786
P: 909.981.5859 F: 909.981.8293

Today's date: _____ Primary/Referring doctor: _____

Last name: _____ First name: _____ Age: Date of birth: _____

Occupation: _____ Gender: Male Female

Chief Complaint: What brings you in to see the doctor?

_____

_____

History of Present Illness: Please tell us more about your problem (onset, duration, severity, side affected, treatments tried, things that make it better, things that make it worse, etc.)

_____

_____

_____

_____

_____

Review of Systems: Do you have any of the following symptoms? Please check all that apply.

Head:	**Eyes:**	**Mouth:**	**Ears:**
Headache	Blurry vision	Tooth pain	Hearing loss (L / R)
Facial pressure	Double vision	Difficulty swallowing	Dizziness
Facial pain	Blindness (L / R)	Mouth Pain	Ringing (L / R)
Facial droop	Itchy eyes	Snoring	Drainage (L /R)
Facial numbness	Watery eyes	Loss of taste	Pain (L / R)
			Itching (L / R)

Nose:	**Neck:**	**General:**	
Runny	Masses	Fatigue	Heartburn
Dry	Pain	Weight loss	Nausea
Bleeding (L / R)	Trouble breathing	Fever	Vomiting
Loss of smell	Hoarseness	Chest pain	Bloody/tarry stools
Stuffy (L / R)	Cough	Shortness of breath	Frequent urination

Urgency	Itchy skin	Nervousness	Easy bruising
Back pain	Skin rash	Trouble sleeping	Excessive thirst
Joint pain	Numbness/tingling	Daytime sleepiness	Heat/cold intolerance
Joint stiffness	Hyperactivity	Easy bleeding	Reaction to environment

Other conditions not listed

_____

_____

_____

Have you had any surgery? Please list with dates:

_____

_____

_____

_____

_____

Past Medical History:

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Glaucoma	Thyroid disease	Renal failure	Cancer	
Cataracts	Bleeding disorders	Anxiety	Headache	
Blindness (L / R)	HIV	Depression	Other _____	
Stroke	Sleep apnea	ADHD	Other _____	
Brain aneurysm	Asthma	Arthritis	Other _____	
Anemia	Emphysema/COPD	Sjogren's disease		
High blood pressure	Bronchitis	Lupus		
Heart disease	Pneumonia	Myasthenia gravis		
Heart attack	GERD	Multiple sclerosis		
Atrial fibrillation	Stomach ulcers	Diabetes		
High cholesterol	Hepatitis	Fibromyalgia		

Medications: Please list any medications you are currently taking:

Name	Strength/Amount	How often

Allergies: Are you allergic to any medications? Yes No

If yes, please list: _____

Family History: Are the any medical problems that run in your family?

Father: _____

Mother: _____

Other: _____

Social History:

Do you use tobacco?	Yes	No	If yes, how many cigarettes a day? How many years have you smoked?
Do you drink alcohol?	Yes	No	If yes, how many drinks per day?
Do you use illicit drugs?	Yes	No	If yes, what kind?
Do you drink caffeine?	Yes	No	If yes, how many cups per day?
Do you add salt to your foods?	Yes	No	

Olcott MD
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Skin History

Describe your history of:

Sun Exposure: _____ Skin Cancer: _____ Acne: _____

Have you ever had Accutane treatment: _____ Other skin problems: _____

Social and Personal

Do you exercise regularly? Yes ❑ No ❑
_____/week or _____/month

Cortisone Injection in the past year? Yes ❑ No ❑
Dosage & Frequency: _____

Have you ever used tobacco? Yes ❑ No ❑
If yes, average # packs per day? _____
Number of years smoking: _____ Years quit: _____

Do you drink alcohol? Yes ❑ No ❑
If yes, how many drinks per week?

Ever used LSD / Speed / Cocaine / Marijuana?
Yes ❑ No ❑ When?

Recent weight change? Yes ❑ No ❑
If yes, ❑ Increase (up) OR ❑ Decrease (down)

Mental Health

Is stress a major problem for you? Yes ❑ No ❑

Do you feel depressed? Yes ❑ No ❑

Do you panic when stressed? Yes ❑ No ❑

Do you have any problems with eating / your appetite? Yes ❑ No ❑

Do you cry frequently? Yes ❑ No ❑

Have you ever attempted suicide? Yes ❑ No ❑

Do you have trouble sleeping? Yes ❑ No ❑

Have you ever been to a counselor? Yes ❑ No ❑

Have you ever taken psychiatric Medication(s)? Yes ❑ No ❑

Do you currently take psychiatric Medication(s)? Yes ❑ No ❑

Should you have cosmetic surgery, please explain how you anticipate your life being different after the procedure?

I acknowledge that the information stated above is true and complete to the best of my knowledge.

_____ _____ _____
Patient/ Guardian Signature Patient/ Guardian name Date

_____ _____
Reviewing Physician Signature Date