KENNETH SANDERS
FACIAL PLASTIC SURGERY

Today's Date: _____

Patient's Personal History

First Name: _____ Last Name: _____

List your medical problems? ☐ *None*

_____
_____
_____
_____

What surgeries have you had? ☐ *None*

_____
_____
_____
_____
_____

Current Medications, Supplements, Vitamins: ☐ *None*
*(**Include: Medicine, Dosage, Usage**)*

_____
_____
_____
_____
_____

Please list ALL Drug Allergies: ☐ **None**

_____
_____

Have you had any problems with anesthesia? Yes No
Have any blood relatives had a serious problem with anesthesia? Yes No
Have you been taking steroids any time within the last 12 months? Yes No
(Cortisone, Prednisone, Hydrocortisone, Decadron) What are you taking? _____

Are you taking aspirin products or blood thinners? Yes No
What are you taking? _____

Are you pregnant? Yes No N/A LMP: _____
Are you Breastfeeding? Yes No
Do/did you smoke/ use nicotine products? Yes No How much? _____ How long? _____
Do you use recreational drugs? Yes No How often? _____
Do you drink alcohol? Yes No How much? _____

PLEASE FILL OUT COMPLETELY