BONNIE BALDWIN MD
COSMETIC SURGERY

DATE: _____

PATIENT NAME_____BIRTH DATE_____

STREET ADDRESS_____CITY_____STATE_____ZIP CODE_____

CELL _____HOME _____

EMAIL_____Would you like to receive emails from our office? YES[] NO[]

SEX [] M [] F AGE_____ []SINGLE []MARRIED []DIVORCED []OTHER _____

EMPLOYER_____OCCUPATION_____

BUSINESS ADDRESS_____BUSINESS PHONE_____

CITY_____STATE_____ZIP CODE_____

EMERGENCY CONTACT

NAME_____RELATIONSHIP_____

PHONE_____CELL PHONE_____

How did you hear about us?

- ❑ My physician — *Full name:*_____ *Number:* _____
- ❑ A friend or family member — *Name:*_____ *Number:* _____
- ❑ The Physician/Practice website — *Other:* _____

Thank you for visiting our office. Board-certified plastic surgeon, Dr. Bonnie Baldwin, created her practice to promote excellence in care for each patient seeking plastic surgical procedures of the face, breast, and body. She seeks to empower women and men to care for themselves by addressing appearance issues that bother them daily and strives to provide surgical results that look natural and refreshing. She diligently attends to every detail from consultation to recovery followed by extended annual checkups to ensure her patients achieve their individual goals. Dr. Baldwin believes feeling good about one's appearance is a foundation of personal confidence and contentment. We want to ensure your questions are addressed at your initial consultation. Please let Dr. Baldwin or her staff know if you need further information.

PATIENT HISTORY

NAME:_____ DATE:_____

PURPOSE OF YOUR VISIT:_____

_____

HAVE YOU PREVIOUSLY HAD ANY TYPE OF GENERAL SURGERY? YES [] NO []

IF YOU ANSWERED YES PLEASE INDICATE TYPE AND YEAR OF SURGERY:_____

_____

_____

_____

HAVE YOU PREVIOUSLY HAD ANY TYPE OF PLASTIC SURGERY? YES [] NO []

IF YOU ANSWERED YES PLEASE INDICATE TYPE AND YEAR OF SURGERY:_____

_____

_____

DO YOU HAVE ANY MEDICAL PROBLEMS?_____

_____

_____

HAVE YOU PREVIOUSLY HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING?

[] DIABETES
[] STROKE
[] VASCULAR
[] HEART DISEASE
[] KIDNEY DISEASE
[] RESPIRATORY, PULMONARY OR LUNG DISEASE
[] BLEEDING TENDENCIES OR BLOOD DISORDERS
[] SERIOUS MEDICAL DISORDERS
[] POOR SCARRING
[] HIV/AUTOIMMUNE DISEASES

HAVE YOU RECENTLY OR ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES [] NO []

(INCLUDING OVER THE COUNTER, HERBAL MEDICATIONS, DIET OR VITAMIN SUPPLEMENTS)

IF YOU ANSWERED YES, PLEASE INDICATE MEDICATIONS:_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES [] NO []

LIST ANY MEDICATIONS YOU ARE ALLERGIC TO:_____

_____

DO YOU SMOKE? YES [] NO [] HOW MUCH DO YOU SMOKE PER DAY?_____

DO YOU DRINK ALCOHOLIC BEVERAGES? YES [] NO []

FREQUENCY? RARELY [] OCCASIONALLY [] OFTEN []

Please initial to verify the information you have provided is complete and accurate. _____