



ANGELA KEEN, M.D  
 PLASTIC & RECONSTRUCTIVE SURGERY  
 CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY  
 6440 South Wasatch Boulevard, Suite 390, Salt Lake City, Utah 84121  
 p 801.278.9062 e md@angelakeen.com w angelakeen.com

PATIENT INFORMATION					
NAME		"NAME"	DATE OF BIRTH	AGE	SEX
ADDRESS			CITY		
			STATE	ZIP	
PREFERRED PHONE #		ALTERNATE PHONE #			
EMAIL ADDRESS		PREFERRED CONTACT METHOD			
REASON FOR CONSULT		HOW DID YOU HEAR ABOUT OUR PRACTICE?			
HOBBIES/WORK		DOES ANYONE LIVE WITH YOU? IF SO, WHO?			
INSURANCE COMPANY		INSURANCE ID #			
EMERGENCY CONTACT		EMERGENCY CONTACT PHONE #			

RESPONSIBLE PARTY IF UNDER 18...			
NAME		RELATION	
ADDRESS (If different from above)		CITY	
		STATE	ZIP
PREFERRED PHONE #		ALTERNATE PHONE #	

**GENERAL PERMIT FOR PROFESSIONAL CARE AND PHOTOGRAPHS:** I hereby give permission to Dr. Angela Keen, MD and associates to render treatment as she/he sees fit upon myself or my dependent and to call any consultant or anesthesiologist, laboratory, personnel, etc., as is deemed advisable in the care of this case. I also agree to be responsible for their charges, as well as the surgeon's, hospital's and/or surgical centers' charges. I understand that photographs before and after surgery are standard of care and I agree to complete this process. I understand photographs may be used for patient education as well as quality assurance purposes. I am advised that though good results are expected, they are not guaranteed.

**Patient's or Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



ANGELA KEEN, M.D.  
 PLASTIC & RECONSTRUCTIVE SURGERY  
 CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY

NAME \_\_\_\_\_

DATE \_\_\_\_\_

SKIN	YES	NO	GENERAL	YES	NO	HEAD AND NECK	YES	NO
NEW OR CHANGING LESIONS			UNEXPLAINED WEIGHT CHANGE			DIFFICULT BREATHING THROUGH NOSE		
HISTORY OF SKIN CANCER			FATIGUE			EYE PAIN		
HEMATOLOGIC	YES	NO	PERSONAL HISTORY OF CANCER			GLAUCOMA		
ABNORMAL BLEEDING/BRUISING			DIABETES			EXCESSIVE TEARING		
ANEMIA			LIVER DISEASE OR HEPATITIS			DRY EYES		
IMMUNOLOGIC	YES	NO	CARDIOVASCULAR	YES	NO	PULMONARY	YES	NO
HIV			HIGH BLOOD PRESSURE			ASTHMA		
LUPUS			CHEST PAIN			CHRONIC RESPIRATORY PROBLEMS		
OTHER AUTOIMMUNE DISEASE:			SHORTNESS OF BREATHE			ENDOCRINE	YES	NO
PSYCHIATRIC	YES	NO	IRREGULAR HEARTBEAT			DIABETES		
DEPRESSION			HISTORY OF HEART DISEASE			THYROID ABNORMALITIES		
ANXIETY			HISTORY OF BLOOD CLOT			NEUROLOGICAL	YES	NO
OTHER:						SEIZURES		
						STROKE		
PLEASE DETAIL ANY "YES" ANSWERS ABOVE AND LIST ANY ADDITIONAL PROBLEMS OR CONCERNS:								

Do you have any allergies or reactions to medications? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list:

\_\_\_\_\_

Number of child births? \_\_\_\_\_ Last Mammogram? \_\_\_\_\_ Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list any **prescription medications** currently being taken:

\_\_\_\_\_

Please list any **herbs and/or vitamins** currently being taken:

\_\_\_\_\_

Please list all prior surgeries including cosmetic procedures:

\_\_\_\_\_

\_\_\_\_\_

Please list your top 3 priorities for Dr. Keen to discuss with you:

\_\_\_\_\_

\_\_\_\_\_

**Notes:**