PATIENT INFORMATION

ANGELA KEEN,M.D.
Plastic Surgery & Skin Care

Patient Information

Name	Date Of Birth	Age	Sex
Address	City State		Zip
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 Surgery & Skin Care | Certified By The American Board Of Plastic Surgery**
2750 Cottonwood Parkway Suite #540 Cottonwood Heights, Utah 84121
p 801.278.9062 | **e** md@angelakeen.com | **w** angelakeen.com

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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 HEPATITISD			RY EYES		
IMMUNOLOGIC	YES	NO	CARDIOVASCULAR	YES	NO	PULMONARY	YES	NO
HIVH			IGH 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		
ANXIETYH			ISTORY 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

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