PATIENT INFORMATION



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

Patient Information					
Name	Date Of Birth	Age	Sex		
Address	City Stat	e Z	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:____

HIVH IGH BLOOD PRESSURE ASTHMA IGH BLOOD PRESSURE ASTHMA IGH BLOOD PRESSURE IGH BLOOD PRESSURE ASTHMA IGH BLOOD PRESSURE	SKIN	YES	NO	GENERAL	YES	NO	HEAD AND NECK	YES	NO
HEMATOLOGIC YES NO PERSONAL HISTORY OF CANCER I GLAUCOMA I I ABNORMAL, BLEEDING/BRUISING I DIABETES I EXCESSIVE TEARING I I ANEMIA I I DIABETES I RESCISSIVE TEARING I I ANEMIA I I LIVER DISEASE OR HEPATTISD I RY EYES I I IMMUNOLOGIC YES NO CARDIOVASCULAR YES NO PULMONARY YES NO HIVH I IGH BLOOD PRESSURE I ASTHMA I I LIPUS I IGH BLOOD PRESSURE I ASTHMA I I OTHER AUTOIMMUNE DISEASE: I SHORTINESS OF BREATHE I DIABETES I I PSYCHIATRIC YES NO IRREGULAR HEARTBEAT I DIABETES I I ANXIETYH I I ISTORY OF BLOOD CLOT I I SEIZURES I PLEASE DETAIL ANY "YES' ANSWERS ABOVE AND LIST ANY ADDITIONAL PROBLEMS OR CONCERNS: ISTRICK NO I <td>NEW OR CHANGING LESIONS</td> <td></td> <td></td> <td>UNEXPLAINED WEIGHT CHANGE</td> <td></td> <td></td> <td>DIFFICULT BREATHING THROUGH NOSE</td> <td></td> <td></td>	NEW OR CHANGING LESIONS			UNEXPLAINED WEIGHT CHANGE			DIFFICULT BREATHING THROUGH NOSE		
ABNORMAL BLEEDINGBRUISING I I DIABETES I EXCESSIVE TEARING I I AREMIA I I LIVER DISEASE OR HEPATITISD I RYEYES I I IMMUNOLOGIC YES NO CARDIOVASCULAR YES NO PULMONARY YES NO HIVH I IGH ELCOD PRESSURE I ASTHMA I I LIPUS I GH ELCOD PRESSURE I ASTHMA I I OTHER AUTOIMMUNE DISEASE: I GH ELCOD PRESSURE I CHRONIC RESPIRATORY PROBLEMS I I PSYCHIATRIC YES NO IRREGULAR HEARTBEAT I DIABETES I I DEPRESSION I I ISTORY OF BLOOD CLOT I I DIABETES I I ANXIETYH I I ISTORY OF BLOOD CLOT I I SEIZURES I I PLEASE DETAIL ANY YES' ANSWERS ABOVE AND LIST ANY ADDITIONAL PROBLEMS OR CONCERNS: I I I I Yes, please list:	HISTORY OF SKIN CANCER			FATIGUE			EYE PAIN		
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IMMUNOLOGIC YES NO CARDIOVASCULAR YES NO PULMONARY YES NO HIVH IC IGH BLOOD PRESSURE IC ASTHMA IC IC <td< td=""><td>ABNORMAL BLEEDING/BRUISING</td><td></td><td></td><td>DIABETES</td><td></td><td></td><td>EXCESSIVE TEARING</td><td></td><td></td></td<>	ABNORMAL BLEEDING/BRUISING			DIABETES			EXCESSIVE TEARING		
HVH IGH BLOOD PRESSURE ASTHMA IGH BLOOD PRESSURE ASTHMA IGH BLOOD PRESSURE IGH BLOOD PRES	ANEMIA			LIVER DISEASE OR HEPATITISD			RY EYES		
LUPUS Image: Chest Pain Image: Chest P	IMMUNOLOGIC	YES	NO	CARDIOVASCULAR	YES	NO	PULMONARY	YES	NO
OTHER AUTOIMMUNE DISEASE: V SHORTNESS OF BREATHE V ENDOCRINE YES NO PSYCHIATRIC YES NO IRREGULAR HEARTBEAT DIABETES DIABETES DIABETES V I DEPRESSION I HISTORY OF HEART DISEASE I THYROID ABNORMALITIES VES NO ANXIETYH I ISTORY OF BLOOD CLOT I I NEUROLOGICAL YES NO OTHER: I I ISTORY OF BLOOD CLOT I SEIZURES ISTORY YES NO YES NO OTHER: I I ISTORY OF BLOOD CLOT I I SEIZURES ISTORY YES NO PLEASE DETAIL ANY YES' ANSWERS ABOVE AND LIST ANY ADDITIONAL PROBLEMS OR CONCERNS: ISTORY ISTORY OF BLOOD CLOT ISTORY ISTORY<	HIVH			IGH BLOOD PRESSURE			ASTHMA		
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DEPRESSIONImage: Solution of the state of the	OTHER AUTOIMMUNE DISEASE:			SHORTNESS OF BREATHE			ENDOCRINE	YES	NO
ANXIETYH ISTORY OF BLOOD CLOT NEUROLOGICAL YES NC OTHER: I ISTORY OF BLOOD CLOT	PSYCHIATRIC	YES	NO	IRREGULAR HEARTBEAT			DIABETES		
OTHER: Image: Selizures Image: Se	DEPRESSION			HISTORY OF HEART DISEASE			THYROID ABNORMALITIES		
PLEASE DETAIL ANY "YES" ANSWERS ABOVE AND LIST ANY ADDITIONAL PROBLEMS OR CONCERNS: Do you have any allergies or reactions to medications? YesNo If yes, please list:	ANXIETYH			ISTORY OF BLOOD CLOT			NEUROLOGICAL	YES	NO
PLEASE DETAIL ANY "YES" ANSWERS ABOVE AND LIST ANY ADDITIONAL PROBLEMS OR CONCERNS: Do you have any allergies or reactions to medications? YesNo If yes, please list: Number of child births? Last Mammogram?Do you smoke? YesNo Please list any prescription medications currently being taken:	OTHER:						SEIZURES		
Do you have any allergies or reactions to medications? YesNo If yes, please list: Number of child births? Last Mammogram?Do you smoke? YesNo Please list any prescription medications currently being taken: Please list any herbs and/or vitamins currently being taken:							STROKE		
Number of child births? Last Mammogram?Do you smoke? YesNo Please list any prescription medications currently being taken: Please list any herbs and/or vitamins currently being taken:	Do you have any allergies or	reaction	-						
					smok	e? Yes	No		
Please list all prior surgeries including cosmetic procedures:	Please list any herbs and/o	or vitam	ins cu	rrently being taken:					
	Please list all prior surgeries i	ncluding	g cosr	netic procedures:					

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

Notes

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