# PATIENT INFORMATION

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

## CONTACT INFORMATION

| 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 Surgery & Skin Care | Certified By The American Board Of Plastic Surgery**
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# PATIENT INFORMATION

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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 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**