konstantin vasyukevich m.d.
ny facial surgery

patient profile

general information

Patient Name _____Today's Date: _____ / _____/ _____

Phone Number _____ Alternative Phone Number _____

E-mail Address _____ Date of Birth _____/ _____/ _____ Gender _____

Mailing Address

_____

_____

Emergency Contact Name _____ Phone Number _____

Family Physician _____ Phone Number_____

Pharmacy _____ Phone Number _____

health questionnaire

Have you ever had heart problems or abnormal condition?	☐ Yes ☐ No
Have you ever had heart catheterization, bypass surgery, or pacemaker?	☐ Yes ☐ No
Are you currently taking Coumadin, Plavix, aspirin or any other blood thinners?	☐ Yes ☐ No
Do you have emphysema, sleep apnea or another breathing condition that is oxygen-dependent?	☐ Yes ☐ No
Do you have a bleeding disorder or experienced excessive bleeding in the past?	☐ Yes ☐ No
Are you currently undergoing radiation therapy or chemotherapy for cancer?	☐ Yes ☐ No
Have you had a history of a connective tissue disorder (e.g., Ehlers Danlos Syndrome)?	☐ Yes ☐ No
Are you currently pregnant?	☐ Yes ☐ No
Have you ever had HIV/AIDS or other chronic infections?	☐ Yes ☐ No
Kidney insufficiency?	☐ Yes ☐ No

Liver insufficiency or cirrhosis? ☐ Yes ☐ No

History of aortic aneurysm? ☐ Yes ☐ No

Have you ever had a seizure disorder or stroke? ☐ Yes ☐ No

Are you allergic to any medications or Latex? ☐ Yes ☐ No

Please list the medications you are allergic to _____

What medications or supplements (prescribed and non-prescribed) are you currently taking?

_____

_____

_____

List your previous surgeries.

_____

_____

Please list any medical problems, conditions, or other health related problems that the doctor should know.

_____

_____

_____

I certify that I have listed all of my current medications, allergies, hospitalizations, medical conditions and previous surgeries to the best of my knowledge and ability.

Patient's Name _____

Signature _____ Date _____/ _____/ _____