4920 SW Lee Blvd.
Lawton, OK 73505
(580) 536-5192

SKIN SECRETS

Dale B. Smith, D.O.

Last Name: _____ First Name: _____

DOB: _____ Age: _____ ___ Male ___ Female SSN: _____

Mailing Address: _____ Zip: _____ City: _____ State: _____

Home Phone: _____ Work: _____ Cell: _____

Employer: _____ City: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Physician: _____ Eye Doctor: _____ Date of last eye exam: _____

Family Physician: _____ Date of last physical exam: _____

How did you hear about us? _____

Are you currently being treated by a psychiatrist/psychologist? ___ No ___ Yes Whom: _____

Have you ever consulted with another physician regarding cosmetic surgery? ___ No ___ Yes Whom: _____

Do you realize that every operative procedure is followed by a period of healing before tissues return to normal and a final result is apparent? ___ Yes ___ No

Do you understand that carefully following instructions on pre-operative and post-operative care along with avoiding sun exposure, tobacco and alcohol use, use of blood thinners such as aspirin, Motrin, etc. are paramount in healing and your final result? ___ Yes ___ No

Have you ever taken Accutane? ___ No ___ Yes When: _____

Do you smoke? ___ No ___ Yes How many packs per day: _____ How many years: _____

Do you take aspirin or blood thinners? ___ No ___ Yes What medication: _____

Have you ever consulted with an attorney or threatened malpractice lawsuit against any doctor, surgeon, or other healthcare provider? ___ No ___ Yes Details: _____

I understand that all services provided through Skin Secrets within the Allergy Ear, Nose & Throat Institute are strictly on a cash basis. Services provided are considered elective and cosmetic and are not covered by healthcare insurance. If for any reason, you feel that a service you are requesting might be covered by insurance or another third party or worker's compensation, you must notify us of this now. I have plans to request services from healthcare insurance, a third party, or worker's compensation. ___ Yes ___ No

I understand photographs of my face and other body areas may be taken and maintained in my file as part of my medical record, and I hereby give consent for the photographs to be taken, stored and used in my treatment. I understand my photos will not be released to another person or entity without my written consent.

I understand my consultation fee of $75.00 is due prior to seeing the doctor and is non-refundable.

Signature: _____ Date: _____

Parent/Legal Guardian (if patient is under 18 years of age): _____ Date: _____

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Cosmetic History Form

Patient Name: _____ **Age:** _____ **Sex:** _____ **Hgt:** _____ **Wgt:** _____

Major cosmetic concerns (Why you came to see the doctor today) **Today's Date:** _____

1. _____
2. _____
3. _____

Prior cosmetic procedures you have had (list type, doctor, and date)

1. _____
2. _____
3. _____

Past Medical History

Review of Systems

Problems you currently have or have been diagnosed with in the past. Please mark all boxes (No/Yes) and add details in blanks

Constitutional

No Yes
__ __ Weight Loss/Gain_____
__ __ Chronic Fever _____
__ __ Anesthetic Reaction _____
__ __ Staph Infections _____
__ __ Birth Complications _____

Neurologic

No Yes
__ __ Head Injury _____
__ __ Seizures _____
__ __ Migraines _____

Eyes

No Yes
__ __ Visual Problems _____
__ __ Double Vision _____
__ __ Dry Eyes _____
__ __ Contact Lenses _____

Head/ Ear Nose Throat

No Yes
__ __ Cold Sore/Fever Blisters _____
__ __ Hearing Loss _____
__ __ Sinus Infections _____
__ __ Dizziness _____
__ __ Smell/Taste Disorder_____
__ __ Nasal Polyps _____
__ __ Nasal Obstruction _____
__ __ Nose Bleeds _____
__ __ TMJ Syndrome _____
__ __ Dental Problems _____
__ __ Hoarseness _____
__ __ Swallowing Problems _____
__ __ Neck Mass/Swelling _____
__ __ Snoring/Apnea _____
__ __ Other _____

Cardiovascular

No Yes
__ __ Heart Attack _____
__ __ Rheumatic Fever/MVP _____
__ __ Stroke/TIA's _____
__ __ Heart Disease _____
__ __ Heart Mumur _____
__ __ High Blood Pressure _____
__ __ Chest Pain _____

Respiratory

No Yes
__ __ Tuberculosis _____
__ __ Chronic Cough _____
__ __ COPD/Asthma _____

Gastrointestinal

No Yes
__ __ Stomach Ulcers _____
__ __ Heartburn/Reflux _____
__ __ Hepatitis _____
__ __ Hiatal Hernia _____

Genitourinary

No Yes
__ __ Kidney Disease _____
__ __ Kidney Infection _____
__ __ Prostate Problems _____
(men only)

Musculoskeletal

No Yes
__ __ Arthritis _____
__ __ Back/Neck Disorders _____

Integument

No Yes
__ __ Skin Disease _____
__ __ Shingles _____
__ __ Excessive scarring _____

Psychiatric

No Yes
__ __ Emotional Disorder _____
__ __ Depression/ Anxiety _____
__ __ PTSD _____
__ __ Addiction to _____

Endocrine

No Yes
__ __ Thyroid Disease_____
__ __ Diabetes_____

Hematologic

No Yes
__ __ Easy Bleeding/ Bruising _____
__ __ Enlarged Lymph Nodes_____
__ __ Cancer _____
__ __ Blood Disease _____

Allergic-Immunologic

No Yes
__ __ Allergies _____
__ __ Hives _____
__ __ Hay Fever _____
__ __ AIDS/HIV _____
__ __ Lupus/Scleroderma _____
__ __ Latex Allergy _____