

## The Initial Visit Form

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ Email \_\_\_\_\_  
What's your preferred method of contact?  Mail  E-mail  Telephone

## Medical/Surgical History

Please list all Medications you currently take: \_\_\_\_\_  
Please list any Allergies to Medications: \_\_\_\_\_  
Have you ever had prescription pain medicine before?  Yes  No If so, for what? \_\_\_\_\_  
Please list any medical conditions that you are aware of: \_\_\_\_\_  
Have you ever taken any allergy medicine?  Yes  No  
Have you been treated for sinusitis ever?  Yes  No  
Have you taken antibiotics for sinusitis in the past 24 months?  Yes  No  
Have you ever taken any products like Afrin or Neosynhepherine nasal sprays to help you breathe better?  Yes  No  
Have you ever taken any nasal steroid or prescription sprays?  Yes  No  
Please list any surgeries that you have had: \_\_\_\_\_  
Have you ever had issues with anesthesia before?  Yes  No  
Do you smoke tobacco? How long? How much?  Yes  No \_\_\_\_\_  
Do you drink wine, beer or liquor? Amount per week?  Yes  No \_\_\_\_\_  
Are there any family or health issues you want the doctor to know about?  Yes  No If yes, \_\_\_\_\_

## Nasal/Facial History and Issues

Have you ever had any facial trauma?  Yes  No  
Have you ever had your nose broken or hit?  Yes  No  
Do you have trouble breathing through your nose?  Yes  No  
Is there a side of your nose that seems to breathe better?  Yes  No  Don't Know  
Do you have trouble breathing through your nose when you exercise?  Yes  No  
Do you awake with a dry mouth regularly?  Yes  No  
Do you have or have ever had nosebleeds?  Yes  No  
Do you have trouble finding glasses that fit your nose well?  Yes  No  
Are you limited to the type of frames for glasses that you can buy because of the shape of your nose?  Yes  No  
Does your nose get sunburned easily?  Yes  No  
Does your forehead get sunburn easily?  Yes  No  
Do you sunburn easily?  Yes  No

## Aesthetic Considerations:

These questions help the doctor understand how you personally view your current nasal aesthetics

Do you have a preferred side to show or position when pictures of you are taken?  Yes  No  Don't Know  
Do you like the overall shape of your nose?  Yes  No  Don't Know  
Is the tip of your nose heavy, boxy or pinched? \_\_\_\_\_  
Is the dorsum of your nose too high or wide? \_\_\_\_\_  
Is your nose tipped up too much?  Yes  No  Don't Know  
Is your nose drooping down too much?  Yes  No  Don't Know  
Are your nostrils symmetric?  Yes  No  Don't Know  
Have you thought about changing the shape of your nose?  Yes  No  
What are your concerns regarding changing the shape of your nose? \_\_\_\_\_  
How soon would you like to arrange for surgery?  Within 6 months  Within 12 months  After 12 months