Welcome
to the office of Dr. Tenley K. Lawton

PLEASE TELL US A LITTLE ABOUT YOURSELF SO THAT WE CAN ACHIEVE OUR GOAL OF PROVIDING YOU WITH OPTIMAL CARE.

ABOUT YOU

Today's Date ______________________________

Name ______________________________

AKA or Nickname ______________________________

Home Address ______________________________

____
City State Zip

Social Security # ______________________________

Birth date ______________________ ❒ Female ❒ Male

Age __________ ❒ Single ❒ Married

❒ Divorced ❒ Widowed ❒ Other

Spouse/Partner Name ______________________________

Home # ______________________________

Work # ______________________________

Cell # ______________________________

Email ______________________________

May we send you email regarding specials? ❒ Yes ❒ No

Preferred Method of Contact ______________________________

Emergency Contact Name ______________________________

Relationship to Patient ______________________________

Emergency Contact # ______________________________

Employer ______________________________

Employer Address ______________________________

____
City State Zip

Occupation ______________________________

What is the name of the person who referred you?

____

May we thank them? ❒ Yes ❒ No

If referred by internet, what site?

❒ Looking your best ❒ Dr.'s Website

❒ General search ❒ Other ______________

Primary Physician Name ______________________________

Primary Physician Address ______________________________

____
City State Zip

Primary Physician Phone # ______________________________

INSURANCE

Are you here for Cosmetic Surgery? ❒ Yes ❒ No

Insurance Name ______________________________

Insurance Policy # ______________________________

Insurance GROUP # ______________________________

Name of Person Insured ______________________________

Insured Birth Date ______________________________

Insured SS# ______________________________

Insured Employer ______________________________

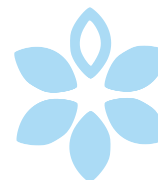
WOULD YOU LIKE INFORMATION ON THE FOLLOWING?

- ☐ BOTOX (Can soften the appearance of the wrinkles around your eyes, forehead, and frown lines)
- ☐ SCULPTRA / JUVEDERM / RADIESSE (Fillers that can improve the appearance of the larger wrinkles around your face, such as laugh lines)
- ☐ CHEMICAL PEEL (A procedure that can improve the appearance of skin, resulted in a smoother, less wrinkled appearance with an even complexion)
- ☐ SKIN CARE PRODUCTS (Physician-prescribed products that treat your skin from the inside out)
- ☐ LATISSE (Enhances eyelash growth)

Thank you for taking the time to complete this questionnaire. The information you have provided will help us ensure the safe practice of plastic surgery. By signing below, you authorize the release of medical information necessary to process insurance claims, you authorize the release of all medical records to/from Tenley K. Lawton, MD, and you request payment of government benefits and all medical benefits be assigned to Tenley K. Lawton, MD. You also agree to pay all charges not covered by your insurance.

Signature ______________________________

Date ______________________________



tenley k lawton m.d.
BOARD CERTIFIED PLASTIC SURGEON

(Continued on Back...)

Just you.... Refined.

MEDICAL HISTORY

Reason for today's visit________________________________

____

When would you like to have surgery?

____

Are you experiencing any of the following problems?

Y	N	New or Changing Skin Lesions	Y	N	Breast pain or lumps
Y	N	Hair or nail changes	Y	N	Cramping when walking
Y	N	Excessive scarring / keloids	Y	N	History of blood clots in veins
Y	N	Headaches	Y	N	Trouble swallowing
Y	N	Weakness	Y	N	Nausea / Vomiting
Y	N	Paralysis	Y	N	Heartburn / Ulcers
Y	N	Numbness / Tingling	Y	N	Abdominal pain
Y	N	Seizures	Y	N	Liver problems
Y	N	Wear Glasses / Contacts	Y	N	Constipation
Y	N	Double Vision / Dry Eyes	Y	N	Diarrhea
Y	N	Temporary blindness	Y	N	Increased urinary frequency
Y	N	Easy bruising / Bleeding	Y	N	Pain when urinating
Y	N	Anemia	Y	N	Heavy periods
Y	N	Bleeding gums	Y	N	Depression
Y	N	Chronic cough	Y	N	Anxiety
Y	N	Blood in sputum	Y	N	Schizophrenia
Y	N	Wheezing	Y	N	Manic episodes
Y	N	Shortness of breath	Y	N	Alcohol / Drug abuse
Y	N	Chest pain	Y	N	Chronic infections
Y	N	Palpitations	Y	N	AIDS / HIV
Y	N	Heart murmur / Valve problems	Y	N	Excessive weight gain / loss

Please list all of your medical illnesses

(Diabetes, hypertension, heart disease, lung disease, etc.)

❒ Check here if you have no past medical history

____

____

____

____

____

Please list all surgeries you have had done and the month and year these were performed

❒ Check here if you have never had surgery before

____

____

____

____

____

____

Height __________Weight __________ Max Weight _________

Please list all allergies (medicines, anesthetics, antibiotics, pain medications)

____

____

____

____

____

Please list all medical problems in immediate family members

____

____

____

____

HABITS

Y N Smoking, # packs/ day ____________________

If former smoker, date quit ________________

Y N Alcohol, # drinks/week ____________________

Y N Drugs now or in past. Type ________________

FOR WOMEN ONLY

Y N Are you, or might you be pregnant?

Y N Are you on birth control?

Y N Did you ever breast feed?

Y N Did you ever take hormone replacements?

\# of pregnancies ____________# of live births___________

Age of 1st period____________Age of menopause _______

Date of last mammogram ________________________

(You are responsible for obtaining a mammogram and a breast exam one month prior to any breast surgery.)

Please list all current medications

❒ Check here if you are taking no medications

____

____

____

____

____