DALLAS RHINOPLASTY CENTER, P.A.

C. SPENCER COCHRAN, M.D. | AESTHETIC & RECONSTRUCTIVE NASAL SURGERY

Medical History Form

Name_____ Date _____
Home Address _____ City: _____ State: _____ Zip: _____
Home phone _____ Cell Phone _____ Email Address _____
Occupation_____ Work phone_____ D.O.B _____
Emergency contact & phone #_____ Pharmacy name & phone #_____

List all Medication, Food, and Makeup ALLERGIES_____
List all medications you are taking: Prescription and Homeopathic as well as Retin A, Glycolic Acid & Acutane, Aspirin, Ibuprofen, Vitamins and all other Over the Counter Meds _____
Have you ever had a MRSA (staph) Infection?_____
If yes, was the infection acquired in a hospital?_____
Do you take prophylactic premeds before having a procedure at the dentist ❑ No ❑ Yes, If so, what?_____
What products do you use for skin care? _____

Do you have any of the following conditions? (Check Yes or No)

Yes	No		Yes	No	
☐	☐	Cold Sores, when? _____	☐	☐	Fainting/Dizzy Spells? _____
☐	☐	Herpes Simplex	☐	☐	Hemophilia
☐	☐	Shingles, when? _____	☐	☐	Prolonged Bleeding why? _____
☐	☐	Dry Eye- Use Drops? _____	☐	☐	Hepatitis _____
☐	☐	Corneal Abrasion, when? _____	☐	☐	Allergic to Cow's Milk Protein
☐	☐	Eye Surgery/ Injury, when? _____	☐	☐	Diabetes?
☐	☐	Cataracts	☐	☐	Chemo/ Radiation (ever)?
☐	☐	Visual Disturbances/ Glaucoma	☐	☐	Use Tobacco Products?
☐	☐	Wear Contacts	☐	☐	Cosmetic Surgeries?
☐	☐	Tumors/ Growths/ Cysts (Circle)	☐	☐	Facial Cosmetic Surgery?
☐	☐	Abnormal Heart Condition _____	☐	☐	Using an eye drops?
☐	☐	High/ Low Blood Pressure (Circle)	☐	☐	Pregnant, or Nursing?
☐	☐	Circulatory Problems			

☐ ☐ Diagnosed with any peripheral motor neuropathic diseases that affect your muscles and nerves, such as: ALS, Lou Gehrig's Disease, Myasthenia Gravis or Lambert Eaton Syndrome.

Have you had any type of Laser, Photofacial, Botox, Dysport, Restylane, Radiesse, Sculptra, Hylaform, Perlane, Collagen, Silicone, Juvederm, Artefill or any other Cosmetic/ Plastic Surgery Procedures performed on your face or have scheduled in the future? If so, Which procedure(s?) Where on your face? When performed or scheduled?)_____
Were you pleased with your result(s?) /any complications/concerns?_____
Any medical concerns about procedure(s) you are interested in today?_____
Who should we thank for sending you to us?_____

Thank you for taking time to fill this out. _____ _____
Signature Date

DALLAS RHINOPLASTY CENTER, P.A.

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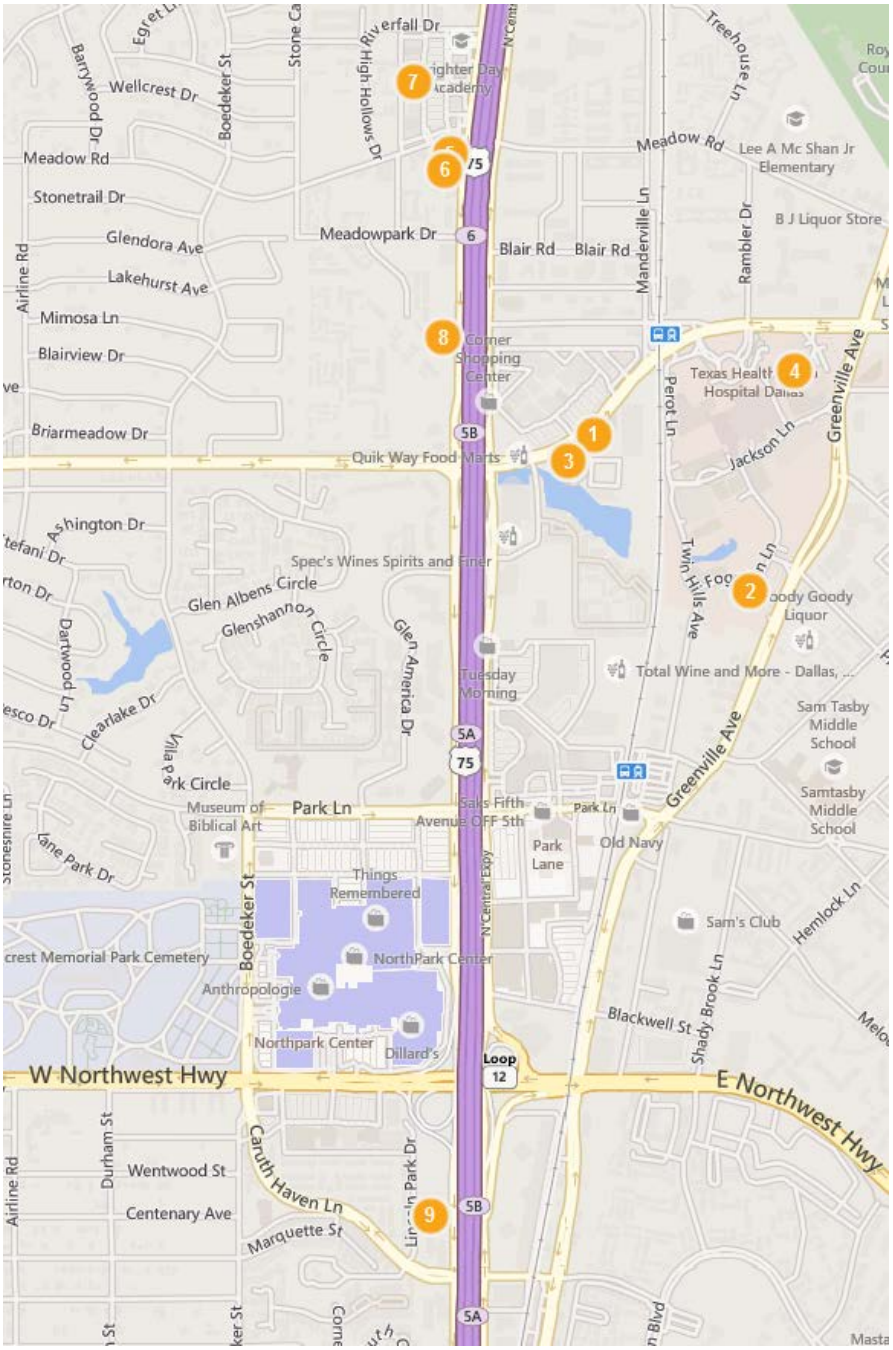
We are conveniently located in North Dallas near North Central Expressway (Hwy 75) and Walnut Hill Lane on the 1st Floor (Suite 170) of the MHBT Building.



1. **Dallas Rhinoplasty Center**
   8144 Walnut Hill Lane, Suite 170
   Dallas, Texas 75231
   (214) 369-8123

2. **Texas Institute for Surgery**
   7115 Greenville Ave
   Dallas, TX 75231
   (214) 647-5300

3. **CVS Pharmacy**
   8024 Walnut Hill Ln
   Dallas, TX 75231
   (214) 368-3050

4. **Southwest Diagnostic Imaging**
   8230 Walnut Hill Ln
   Dallas, TX 75231

5. **Residence Inn**
   10333 N Central Expy
   Dallas, TX 75231
   (214) 750-8220

6. **Marriot Courtyard**
   10325 N Central Expy
   Dallas, TX 75231
   (214) 739-2500

7. **Tom Thumb Pharmacy**
   10455 N Central Expy
   Dallas, TX 75231
   (214) 369-7328

8. **La Quinta Inn**
   10001 N Central Expy
   Dallas, TX 75231
   (214) 361-8200

9. **Hyatt House Dallas/Lincoln Park**
   8221 N Central Expy
   Dallas, TX 75225
   (214) 696-1555

8144 WALNUT HILL LANE, SUITE 170 DALLAS, TEXAS 75231
(TEL) 214.369.8123 (FAX) 214.369.2984
WWW.RHINOPLASTY-USA.COM WWW.GUNTER-CENTER.COM
INFO@GUNTER-CENTER.COM

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ____ **Patient ID #:** _______________________

I hereby acknowledge that I have received a copy of DALLAS RHINOPLASTY CENTER's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

I AUTHORIZE THAT MESSAGES FOR PATIENT PERTAINING TO APPOINTMENTS AND INSTRUCTIONS REGARDING PATIENT CARE MAY BE LEFT

- ❑ at work
- ❑ cell phone
- ❑ with spouse
- ❑ at home/voicemail
- ❑ via email
- ❑ other relative

____
Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

- -

(FOR OFFICE USE ONLY)

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

_____________________________ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

____
____
____
____
____

- ☐ Other (Specify)

____
____
____
____

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