EYE & FACIAL
PLASTIC SPECIALISTS
Dr. Donald Hollsten & Dr. Jordan Hollsten

New Patient Information
(non-insurance)

Last Name _____ **First Name** _____ **MI** _____

(circle one) Dr. Mr. Mrs. Ms. Other **(circle one)** Jr. Sr. Other **Nickname** _____

Street Address _____ **Suite/Apt.** _____

City _____ **State** _____ **Zip** _____

Email _____

Home Phone _____

Cell Phone _____

Alt. Phone _____

Date of Birth _____ **SSN** _____

Marital Status (circle one) Single Married Divorced Widowed Partner **Sex** M F N.B.

Primary Care Physician _____

Cardiologist _____

Emergency Contact _____ **Emergency Phone** _____

REFERRAL SOURCE
How did you find our office?

- ❑ Physician _____
- ❑ Friend or Family Member _____
- ❑ Magazine Article or Advertisement _____
- ❑ Website

  _____
- ❑ NPR
- ❑ Google

SIGNATURE _____ **DATE** _____

PATIENT MEDICAL HISTORY *(check all that apply)*

Ear/Nose/Throat

- ❑ Hearing Loss
- ❑ Sinus Problems
- ❑ Sore Throat
- ❑ Other _____

Heart Issues

- ❑ Chest Pain
- ❑ Irregular Heartbeat
- ❑ Heart Attack
- ❑ Pacemaker
- ❑ Other _____

Urinary Issues

- ❑ Pain or Discomfort
- ❑ Blood in Urine
- ❑ Other _____

Skin Problems

- ❑ Excessive Dryness
- ❑ Other _____

Musculoskeletal Issues

- ❑ Muscle Aches
- ❑ Joint Pain
- ❑ Swollen Joints
- ❑ Other _____

Psychiatric Issues

- ❑ Depression
- ❑ Anxiety
- ❑ Other _____

Respiratory Issues

- ❑ Asthma
- ❑ Shortness of Breath
- ❑ Coughing
- ❑ Other _____

Gastrointestinal Issues

- ❑ Heartburn
- ❑ Belly Pain
- ❑ Diarrhea
- ❑ Other _____

Neurological Issues

- ❑ Numbness
- ❑ Weakness
- ❑ Headaches
- ❑ Paralysis
- ❑ Other _____

Miscellaneous

- ❑ High Blood Pressure
- ❑ Cancer _____
- ❑ Immune System Disorder
- ❑ Thyroid Disease
- ❑ Stroke
- ❑ Bleeding Disorder
- ❑ Hyperlipidemia
- ❑ Diabetes
- ❑ _____

Have you ever been diagnosed with any of the following eye conditions? *(check all that apply)*

☐ Glaucoma ☐ Wandering Eye ☐ Droopy Eyelid

☐ Cataract ☐ Detached Retina ☐ Other _____

PATIENT SURGICAL HISTORY

Procedure _____ Date_____

Procedure _____ Date_____

Procedure _____ Date_____

Procedure _____ Date_____

*List additional Procedures on the back of this page

ALLERGIES

Food	Yes	No	_____
Medicine	Yes	No	_____
Environmental	Yes	No	_____

SMOKING HISTORY Never Current Former

ALCOHOL USE Number of Drinks Per Day _____ Number of Drinks Per Week _____

FAMILY MEDICAL HISTORY (*Check all that apply)*

☐ Diabetes	Family Member _____
☐ High Blood Pressure	Family Member_____
☐ Cancer	Family Member _____
☐ Stroke	Family Member _____
☐ Bleeding Disorder	Family Member _____
☐ Asthma	Family Member _____
☐ Immune System Disorder	Family Member _____
☐ Other _____	Family Member _____

MEDICATIONS/ SUPPLEMENTS

Please Provide the front desk with a Full List of Medications or Write List on Back of This Page

SIGNATURE _____ **DATE** _____

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PATIENT NAME: _____ **DATE:** _____

	MEDICATION	DOSE	FREQUENCY
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____
14.	_____	_____	_____
15.	_____	_____	_____