Print Form

AESTHETIC FACIAL PLASTIC SURGERY PLLC
DR. PHILIP YOUNG, MD

PATIENT INFORMATION FORM

Confidential Information: The information herein will not be released except when you have authorized us to do so. This information will be used by the doctor(s) in their decisions regarding your care.

Patient Name: _____ DOB: _____ SSN: _____

Mailing Address: _____ City: _____ State: _____ ZipCode: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Email Address: _____ Height: ____ ft ____ in Weight: _____

*May we contact you via email for appointment reminders? ☐ Yes ☐ No
*May we email you about future promotions/discounts and/or Information regarding events held by our office? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other: _____

Occupation: _____ Job Duties Include: _____

Primary Care Physician: _____ Phone : _____ Date of Last Visit: _____

Emergency Contact: _____ Relation: _____ Phone: _____

What are your primary cosmetic goals / concerns? _____

How did you hear about us?

☐ Postcard/Flyer ☐ Magazine ☐ AFPS Website ☐ TV
☐ Google (Organic) ☐ Google (Sponsored) ☐ Yahoo (Sponsored) ☐ Yahoo (Organic)
☐ Newspaper: Korean/Chinese/Vietnamese (Circle One) ☐ Referral: _____ ☐ Patient: _____
☐ Other: _____

Statement of Financial Responsibility: I, the undersigned, have read the above and realize that medical and surgical charges incurred by me or my dependents for services rendered by Aesthetic Facial Plastic Surgery, PLLC are my financial responsibility. All collection fees or court fees necessary to collect this account are payable by me.

Signature of Financially Responsible Party: _____ Date: _____

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PATIENT HEALTH QUESTIONNAIRE

Please List all surgical operations, including procedures done for cosmetic reasons:

Procedure:		**Date:**	
Procedure:		**Date:**	
Procedure:		**Date:**	

Have you experienced any problems with anesthesia in the past? ☐ Yes ☐ No

If yes, what type of anesthesia was used and describe any problems: _____

_____

Do you or have you ever had any of the following: *(Check Yes or No)*					
Seizure/Epilepsy	☐Y ☐N	Hepatitis A, B, C, D, E (circle one)	☐Y ☐N	Cold Sores/Herpes	☐Y ☐N
Eye Spasms/Blepharospasms	☐Y ☐N	Heartburn/Esophageal reflux	☐Y ☐N	Polio/Paralysis	☐Y ☐N
Snoring/Sleep Apnea	☐Y ☐N	Back pain/injury	☐Y ☐N	Stroke(s)	☐Y ☐N
High blood pressure	☐Y ☐N	Diabetes (Type 1 or 2)	☐Y ☐N	Easy Bleeding/Bruising	☐Y ☐N
High Cholestoral	☐Y ☐N	Thyroid Disease	☐Y ☐N	Lung disease/trouble	☐Y ☐N
Heart Failure	☐Y ☐N	Excessive Clotting	☐Y ☐N	Tuberculosis	☐Y ☐N
Heart Attacks	☐Y ☐N	Anemia	☐Y ☐N	Cancer: Type _____	☐Y ☐N
Heart Murmur	☐Y ☐N	HIV/AIDS	☐Y ☐N	**Other:**_____	☐Y ☐N
Asthma/Emphysema	☐Y ☐N	Numbness of arms/legs	☐Y ☐N	_____	

Can you walk up 2 flights of stairs without having chest pain or shortness of breath? ☐ Yes ☐ No

Do you currently use: Eyeglasses ☐ Yes ☐ No Hearing Aid(s) ☐ Yes ☐ No
Contact Lenses ☐ Yes ☐ No Dentures ☐ Yes ☐ No

Please list any other and family medical history (including cancer(s), diabetes, high blood pressure, stroke(s), heart attack, etc.):

_____

_____

Are you allergic to any drugs or medications? ☐ Yes ☐ No Are you allergic to Latex? ☐ Yes ☐ No

If yes, please list all drugs and side effects: _____

_____

Please <u>list all</u> current prescription, OTC medications, and supplements you are taking (including birth control, blood thinners, hormones, and vitamins, herbal supplements, diuretics, and weight loss drugs):

Dosage & Times/Day:

Do you take any of the following? Aspirin: ☐ Yes ☐ No Vitamin E: ☐ Yes ☐ No Fish Oil: ☐ Yes ☐ No

Anti-inflammatory or steroid medication (ex. Motrin, Aleve, Ibuprofen, Excedrin, naproxen, Advil)? ☐ Yes ☐ No

Are you or could you be pregnant? ☐ Yes ☐ No

Do you have a history of smoking? ☐ Yes ☐ No How much do/did you smoke? _____ Packs/day _____ Yrs Smoked

Have you smoked in the past 12 months? ☐ Yes ☐ No When did you quit smoking? Date: _____

Do you consume alcohol? ☐Yes ☐No If yes, how often? ☐ Rarely (0-1 drinks/mo) ☐ Occasionally (2-4 drinks/mo)
☐ Socially (6-10/mo) ☐ Regularly (1-2/day) ☐ Frequently (3-4/day)

Do you have a history of using recreational drugs? ☐ Yes ☐ No How many years? _____ How much? _____

If yes, please indicate which type(s): ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Ecstasy ☐ Vicodine ☐ Morphine ☐ Methamphetamine

Do you exercise regularly? ☐Yes ☐No If yes, how often? _____

Do you get chest pain or shortness of breath during or after exercise? ☐Yes ☐No

Have you ever been under psychiatric care? ☐ Yes ☐ No

If yes, when? _____ Reason: _____

_____