 **Reset**

**PATIENT INFORMATION FORM**

Legal Name: Sex: Female Male

Mailing Address: City: State: Zip Code:

Occupation: Home Phone:

**Date of Birth**:

Cell Phone: Other Phone:

EmailAddress:



\*May we contact you via email for appointment reminders?

\*May we email you about future promotions/discounts and/or information regarding events held by our office?

Yes

No

Yes

No

Emergency Contact: Relation: Phone: Primary Care Provider: Phone : Date of LastVisit:

**How did you hear about us?**

Google: Organic/Sponsored (Circle One) Yahoo: Organic/Sponsored (Circle One)

TV: New Day Northwest/Hallmark/Bravo/Lifetime(Circle One) Newspaper: Korean/Chinese/Vietnamese (CircleOne)

AFPS Website

Postcard/Flyer

Magazine

Referral:

Patient:

Other:

**What are your primary cosmetic goals / concerns**

**How long have you been thinking about these procedures:**  **What date did you have in mind for your procedures:**  **How long have you been researching our Team or Doctor:**

**Who do you have that can take care of you after your procedure &**

**that can support you through the recovery (family or friends):**

**Tell us something personal about you that you would like to share:**

**PATIENT HEALTH QUESTIONNAIRE**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | HIV/AIDS | Y | N |
| Snoring/Sleep Apnea | Y | N | Heartburn/Esophageal reflux | Y | N | Cold Sores/Herpes | Y | N |
| High blood pressure | Y | N | Back pain/injury | Y | N | Polio/Paralysis | Y | N |
| High Cholesterol | Y | N | Diabetes (Type 1 or 2) | Y | N | Easy Bleeding/Bruising | Y | N |
| Heart Failure | Y | N | Hyperthyroidism | Y | N | Lung disease/trouble | Y | N |
| Heart Attacks | Y | N | Hypothyroidism | Y | N | Tuberculosis | Y | N |
| Heart Murmur | Y | N | Excessive Clotting | Y | N | Cancer: Type | Y | N |
| Asthma/Emphysema | Y | N | Anemia | Y | N | **Other:** | Y | N |



**Have you had any problems with Anesthesia in the Past: Please list previous surgical operations, including procedures done for cosmetic reasons:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Procedure:** |  | **Date:** |  |
| **Procedure:** |  | **Date:** |  |
| **Procedure:** |  | **Date:** |  |
| **Procedure:** |  | **Date:** |  |

**Please list any new symptoms that you may be experiencing:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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 all current prescription, OTC medications, and supplements you are taking** including birth control, blood thinners, hormones, and vitamins, herbal supplements, diuretics, and weight loss drugs : (*please note the dose and how often you take it)*

Please list any Family History of Medical Problems:

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:

Anti-inflammatory or steroid medication (ex. Motrin, Aleve, Ibuprofen, Excedrin, naproxen, Advil)?

Yes No

Do you take any ofthe following? Aspirin:

Yes

No Vitamin E:  Yes No Fish Oil:  Yes  No

Are you or could you be pregnant? Do you have a history of smoking?

Have you smoked in the past 12 months?

Yes Yes

No Date of lastperiod:

No How much do/did you smoke? Packs/day Yrs Smoked 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

Vicodin

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

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

Have you ever been under psychiatric care?

Yes

No If Yes, when?

Reason:

Height: ft in Weight: lbs

Aesthetic Facial Plastic Surgery values the privacy of its patients and is committed to operate our practice in a manner that promotes patient confidentiality while providing high quality patient care. In order to do so, we will not release any information regarding your care here except when you have authorized us to do so. This information will be used by the doctor(s) in their decisions regarding your care.

Please list the following person or persons that we may release your protected information with:



Name: Relationship: Phone #:

Name: Relationship: Phone #:

**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.

Print Patient’sName:

Patient’s signature: Date: