



AESTHETIC FACIAL BODY PLASTIC SURGERY
DR. PHILIP A. YOUNG, MD DR. RIKESH T. PARIKH, MD

PATIENT INFORMATION FORM

Legal Name: _____ Sex: Female Male
 Mailing Address: _____ City: _____ State: _____ Zip Code: _____
 Occupation: _____ Date of Birth: _____
 Home Phone: _____ Cell Phone: _____ Other Phone: _____
 Email Address: _____

*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

Emergency Contact: _____ Relation: _____ Phone: _____
 Primary Care Provider: _____ Phone: _____ Date of Last Visit: _____

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 (Circle One)
 AFPS Website Postcard/Flyer Magazine
 Referral: _____ Patient: _____ Other: _____

What are your primary cosmetic goals / concerns _____

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:	

PATIENT HEALTH QUESTIONNAIRE

Do you or have you ever had any of the following: (Check Yes or No)					
Seizure/Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis A, B, C, D, E (circle one)	<input type="checkbox"/> Y <input type="checkbox"/> N	HIV/AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N
Snoring/Sleep Apnea	<input type="checkbox"/> Y <input type="checkbox"/> N	Heartburn/Esophageal reflux	<input type="checkbox"/> Y <input type="checkbox"/> N	Cold Sores/Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N
High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Back pain/injury	<input type="checkbox"/> Y <input type="checkbox"/> N	Polio/Paralysis	<input type="checkbox"/> Y <input type="checkbox"/> N
High Cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes (Type 1 or 2)	<input type="checkbox"/> Y <input type="checkbox"/> N	Easy Bleeding/Bruising	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart Failure	<input type="checkbox"/> Y <input type="checkbox"/> N	Hyperthyroidism	<input type="checkbox"/> Y <input type="checkbox"/> N	Lung disease/trouble	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart Attacks	<input type="checkbox"/> Y <input type="checkbox"/> N	Hypothyroidism	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive Clotting	<input type="checkbox"/> Y <input type="checkbox"/> N	Cancer: Type	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma/Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N	Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Other:	<input type="checkbox"/> Y <input type="checkbox"/> N



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

Have you had an unplanned weight loss of more than 15 lbs. in the last 3 months? _____

Do you have night sweats? _____ Have you had a productive cough for the past 3 months? _____

Have you experienced a loss of appetite? _____

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 of the following? Aspirin: Yes No Vitamin E: Yes No Fish Oil: Yes No

Are you or could you be pregnant? Yes No Date of last period: _____

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 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: _____



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Name: _____ Relationship: _____ Phone #: _____

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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.

*Do you understand and agree to the Financial Cancellation policy on our website Yes No

Print Patient's Name: _____

Patient's signature: _____ Date: _____