Nayak Plastic Surgery
Patient Health/Skin History Form

Name ______________________________ Today's Date ______________

Date of Birth ______________ Age _____ Sex _____ Height ______ Weight ______

Primary Care Physician______________________________

Referred by ______________________________

Procedures I would like to discuss with the doctor:

Facial Rejuvenation: Necklift Facelift Eyelid Correction Forehead/Brow Lift Fat Transfer

Nasal Surgery: Cosmetic Corrective Sinus/Septum Problems

Profile Surgery: Chin Implant Cheek Implant Facial/Neck Liposuction

Ear Surgery: Reduce Prominence Reduce Earlobe Size Repair Torn Earlobe

Skin Rejuvenation: Skin growths/moles Wrinkles Pigmentation/Age Spots Redness/Rosacea Broken Blood Vessels Roughness Scars Large pores Acne Acne Scarring Other

Injectables: Botox Collagen Restylane Radiesse Sculptra Lip Augmentation Other

Other Procedures: Hair removal Microlaser Peel Chemical peels Photofacials

Spider Veins: Face Legs

Body: *Take Shape for Life* Medical Weight Loss/Management Zeltiq CoolSculpting Fat Reduction

Please indicate in your own words what concerns you:

____

____

Have you ever had or used:

yes no

Retin A
Chemical peels
Microdermabrasion
Laser, type ______________
Botox
Restylane, Collagen, etc
Silicone
Accutane
Herpes (or cold sore) medication
Oral contraceptives

Current skin care regimen:

Cleanser ______________________________
Toner ______________________________
Scrub ______________________________
Exfoliator ______________________________
Sunscreen ______________________________
Moisturizer ______________________________
Other ______________________________

Sun exposure:
Past: Little Excessive
Present: Little Excessive

Tanning Beds:
Past: Little Excessive
Present: Little Excessive

Sunscreen:
Never Occasional Daily

Review of Systems

Please circle any symptoms below that you feel are affecting your health:

General: Fatigue, unexplained weight gain/loss, fever, chills, night sweats, sleep problems, pain.

Skin: New or changing skin growth, unexplained rash.

Head: Headaches, recent trauma.

Eyes: Blurred/loss of vision, eye pain, discharge, glasses/contacts, **dryness, lasik, glaucoma**

Ears: Excessive noise exposure (loud music), ear pain, loss of hearing, ringing in ears, drainage.

Nose: Frequent bloody nose, sinus pain, post nasal drainage, congestion.

Mouth: Tooth pain, oral sores, bleeding.

Throat: Hoarse voice, voice changes, pain or difficulty swallowing, frequent soreness or swelling.

Neck: Pain, stiffness, swelling.

Chest: Breast changes or lumps, nipple discharge, chest wall pain.

Lungs: Cough, shortness of breath, wheezing.

Heart: Murmurs, palpitations, pain with exertion, passing out.

Stomach: Frequent nausea, vomiting, diarrhea, constipation, abdominal pain, bleeding, constipation.

Urinary Tract: Frequent urination, pain on urination, blood in urine.

Musculoskeletal: Joint pain, swelling, muscle pain, stiffness, restricted movement, swelling.

Nervous System: Loss of consciousness, dizziness, seizures, weakness or numbness in any body part, tremors, twitching.

Mental Health: Feelings of nervousness/anxiety/panic, crying spells, depression, confusion, problems concentrating.

Blood/Lymph: Anemia, bleeding tendency, easy bruising, swollen/painful lymph nodes.

Other: ____

Personal/Family Medical History

Please check where you or members of your family, have had the following:

	Yourself	Father	Mother	Father's Side	Mother's Side	Brother(s)	Sister(s)
AIDS/HIV							
Alcoholism							
Anemia							
Anxiety							
Arthritis							
Asthma							
Bleeding Problem							
Cancer							
Cirrhosis							
Dementia							
Depression							
Diabetes Mellitus							
Eczema, Hives Rash							
Eye Problem/Glaucoma							
Heart Disease/Murmur							
Hemophilia							
High/Low Blood Pressure							
High Cholesterol							
Kidney/Bladder Problem							
Liver Disease/Jaundice							
Lung Disease							
Mental Illness							
Osteoporosis							
Parkinson's Disease							
Peptic Ulcer Disease							
Phlebitis/Blood Clot							
Rheumatic Fever							
Seizures/Epilepsy							
Sickle Cell Disease							
Stroke							
Thallasemia							
Thyroid Disease							
Tuberculosis							

Other: ____
____
____

Allergies:	**Please list all current medications**
☐ None ☐ Medication Allergies____________________________ ____ ☐ Latex ☐ Other ______________________________	Prescription Drugs: Name / Dose / Reason for taking it ____________ ______ __________________ ____________ ______ __________________ ____________ ______ __________________ ____________ ______ __________________ ____________ ______ __________________ ____________ ______ __________________
General/Social Information: Would you be able to lie on your back comfortably for 4 hours? ☐ No ☐ Yes Do you smoke? ☐ No ☐ Yes ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Other________________ If yes, how much? __________ How long? ___________ Are you a former smoker? ☐ No ☐ Yes If yes, when did you quit? ____________________ Do you drink alcohol? ☐ No ☐ Yes If yes, how much and how often do you drink? _____ _________ per ___________________ # of drinks (day, week, month or year) Exercise: how much/what kind? ____	Over the counter: (aspirin, Tylenol, antihistamines, herbals, vitamins, etc) Name / Dose / Reason for taking it ____________ ______ __________________ ____________ ______ __________________ ____________ ______ __________________ ____________ ______ __________________ ____________ ______ __________________ ____________ ______ __________________
Have you ever used intravenous or recreational drugs? ☐ No ☐ Yes If yes, please list: __________________ Are you pregnant or nursing? ☐ No ☐ Yes With whom do you live? ☐ I live alone. ☐ I live with __________________ Are you currently: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated Current occupation/employment: ☐ Retired ☐ Disabled ☐ Working as _______________ Who do you want notified in case of emergency? ________________ ____________ ___________ (Name) (relationship) (phone #)	**Please list current illnesses/health problems**: _______ ____ ____ ____ ____ **Please list surgeries and hospitalizations**: Year ______________________________ _________ ______________________________ _________ ______________________________ _________ ______________________________ _________ ______________________________ _________ ______________________________ _________

ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL. I HEREBY ASSIGN ALL MEDICAL AND SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS INCLUDING MEDICARE, PRIVATE INSURANCE, AND OTHER PLANS TO NAYAK PLASTIC SURGERY, PC. I GIVE AUTHORIZATION TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY THAT IT MAY NEED.

I, THE UNDERSIGNED, DO HEREBY GIVE MY CONSENT FOR NAYAK PLASTIC SURGERY, PC, TO FURNISH TREATMENT CONSIDERED NECESSARY, AND PROPER IN DIAGNOSING AND/OR TREATING MY PHYSICAL AND COSMETIC CONDITION(S).

_______________________________________ _______________________________________
Patient Signature Physician Signature

☐ Form completed by ______________________________ ___________________________
Person other than patient Date Reviewed