

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

Other: _____

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:

	Y yourself	F Father	M Mother	F Father's Side	M Mother's Side	B Brother(s)	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							
Thalassemia							
Thyroid Disease							
Tuberculosis							

Other: _____

Allergies:

- None
- Medications _____
- _____
- Latex
- Other _____

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)

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 all current medications

Prescription Drugs:

<u>Name</u>	<u>Dose</u>	<u>Reason for taking it</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Over the counter: (aspirin, Tylenol, antihistamines, herbals, vitamins, etc)

<u>Name</u>	<u>Dose</u>	<u>Reason for taking it</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list current illnesses/health problems: _____

Please list surgeries and hospitalizations:

	<u>Year</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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