

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: mNecklift mFacelift mEyelid Correction mForehead/Brow Lift mFat Transfer

Nasal Surgery: mCosmetic mCorrective mSinus/Septum Problems

Profile Surgery: mChin Implant mCheek Implant mFacial/Neck Liposuction

Ear Surgery: mReduce Prominence mReduce Earlobe Size mRepair Torn Earlobe

Skin Rejuvenation: mSkin growths/moles mWrinkles mPigmentation/Age Spots mRedness/Rosacea mBroken Blood Vessels mRoughness mScars mLarge pores mAcne mAcne Scarring m Other

Injectables: mBotox mCollagen mRestylane mRadiesse mSculptra mLip Augmentation mOther

Other Procedures: mHair removal mMicrolaser Peel mChemical peels mPhotofacials

Spider Veins: mFace mLegs

Other: _____

Please indicate in your own words what concerns you:

Have you ever had or used:

yes no

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

Current skin care regimen:

- Cleanser _____
- Toner _____
- Scrub _____
- Exfoliator _____
- Sunscreen _____
- Moisturizer _____
- Other _____

Sun exposure:

Past: mLittle mExcessive
Present: mLittle mExcessive

Tanning Beds:

Past: mLittle mExcessive
Present: mLittle mExcessive

Sunscreen:

mNever mOccasional mDaily

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: _____

<p>Allergies: <input type="checkbox"/> None <input type="checkbox"/> Medications _____ _____ <input type="checkbox"/> Latex <input type="checkbox"/> Other _____</p> <p>General/Social Information: Do you smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Other _____ If yes, how much? _____ How long? _____ Are you a former smoker? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when did you quit? _____</p> <p>Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how much and how often do you drink? _____ _____ per _____ # of drinks _____ (day, week, month or year)</p> <p>Have you ever used intravenous or recreational drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please list: _____</p> <p>Are you pregnant or nursing? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>With whom do you live? <input type="checkbox"/> I live alone. <input type="checkbox"/> I live with _____</p> <p>Are you currently: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated</p> <p>Current occupation/employment: <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Working as _____</p> <p>Who do you want notified in case of emergency? _____ (Name) (relationship) (phone #)</p>	<p>Please list all current medications Prescription Drugs:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Name</th> <th style="text-align: left; border-bottom: 1px solid black;">Dose</th> <th style="text-align: left; border-bottom: 1px solid black;">Reason for taking it</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table> <p>Over the counter: (aspirin, Tylenol, antihistamines, herbals, vitamins, etc)</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Name</th> <th style="text-align: left; border-bottom: 1px solid black;">Dose</th> <th style="text-align: left; border-bottom: 1px solid black;">Reason for taking it</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table> <p>Please list current illnesses/health problems: _____ _____ _____ _____</p> <p>Please list surgeries and hospitalizations:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"></th> <th style="text-align: left; border-bottom: 1px solid black;">Year</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </tbody> </table>	Name	Dose	Reason for taking it	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	Name	Dose	Reason for taking it	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____		Year	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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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