Reset

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 (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

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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 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:

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: _____