New Patient Demographics

Please fill in the following information completely

Name: ____ **DOB:**_____/_____/_________

Address:____

City:____ **State:**________ **Zip:**______________

Phone:(______)______-________(hm,cell,wk) **Alt. Phone:**(______)______-________(hm,cell,wk)

Email:________________________________@___________________

Vega Plastic Surgery & MedSpa Mailing List: ❑**YES** ❑**NO**

SSN:_________-________-____________ (required for hospital admissions)

Primary Insurance

Carrier:________________________________

ID #:___________________________________

Subscriber/DOB:________________________

Secondary Insurance

Carrier:______________________________

ID #:__________________________________

Subscriber/DOB:_______________________

Pharmacy/Location/Phone:____

Referring Physician:_________________________ **Phone:**(_____)_________-___________

Primary Care Doctor:________________________ **Phone:**(_____)_________-____________

Emergency Contact:_______________________ **Relationship:**_______________________

Phone:(_____)_______-____________ **Alternate Phone:**(_____)_______-___________

Referred by (if not by a physician) ____

Medical Information Release

I authorize that Vega Plastic Surgery may discuss protected health information, including lab/test results, with the following people:

Name	Relationship	Phone

Medical Record Release

I authorize Vega Plastic Surgery & MedSpa to release any and all of my medical records, including, but not limited to: records of office visits and treatment rendered, clinical laboratory reports, diagnostic test results and x-rays. Such records may be released to another physician or any other health care professional or facility for the purpose of discussing my conditions, consulting on my case, or reviewing my medical records. These records in their entirety, regardless of coverage, may also be released to any government agencies, insurance companies and employees of insurance companies for the purpose of pursuing payment, insurance reimbursement, submitting claims for services rendered or to be rendered to me or performing quality assurance reviews as required by law.

Signature:____ **Date:**___________________

Medical Health History

Vega Plastic Surgery 1050 Pittsford Victor Road Pittsford, NY 14534
Phone 585-383-4040 Fax 585-383-4051

Name:__________________________ **Phone**: **Home**:_______________ **Cell**:________________**Work**:________________

Date of Birth:__________________ **Age:**________ **Sex**: ☐ Male ☐ Female Your **height**:__________Your **weight**:_________

Primary Care Physician: ____ **Doctors Phone**: ____________________________

Have you ever had a Stress Test, Cardiac Work up, Echocardiogram or any other tests for your heart? ❑ **No** If **YES** LIST NAME OF TEST, DATE AND LOCATION: ____
DO YOU HAVE A HEART STENT? ❑ No ❑ Yes Date stent was inserted: ________________________________
DO YOU GET SHORT OF BREATH WHEN YOU WALK UP ONE FLIGHT OF STAIRS? ❑ No ❑ Yes
HAVE YOU EVER HAD AN ABNORMAL EKG? ❑ No ❑ Yes If yes where EKG was done:______________________
Are you allergic to the following food? ❑No ❑Yes ❑Eggs ❑Bananas ❑Avocados ❑Soy ❑Kiwi /Reaction:____________
Are you allergic/sensitive to **latex** (rubber)? ❑ No If yes, Reaction: ❑ Skin rash or swelling ❑ Respiratory (Wheezing)
Are you allergic to any medications? ❑No ❑Yes

Medication Allergy	Reaction to Medication

Please list your current medications: ❑ No medications at this time

Medication ❑ See attached list	Dose	Frequency	Route	**Last Dose Taken Day of Surgery** to be Completed by Preoperative Nurse

Do you have a **COUGH, COLD or FEVER** at this time? ❑ No ❑ Yes
Do you now have or have you ever had any of the following medical problems: **Please explain on a separate page if needed.**

High blood pressure	Yes	No
Under good control?	Yes	No
A heart attack	Yes	No
Congestive heart failure	Yes	No
Heart murmur	Yes	No
History of PFO (hole in heart)	Yes	No
Chest pain or pressure	Yes	No
Irregular heart beat	Yes	No
Pacemaker / defibrillator	Yes	No
Heart valve replacement	Yes	No
Sleep apnea	Yes	No
Do you have or use CPAP	Yes	No
Asthma / last attack____________	Yes	No
Emphysema / COPD	Yes	No
Home oxygen use	Yes	No
Heartburn or reflux	Yes	No
Good control?	Yes	No
Hiatal hernia	Yes	No

Diabetes	Yes	No
Good Blood Sugar control (diabetics)	Yes	No
Hypoglycemia	Yes	No
Neurological Disorders (weakness)	Yes	No
Seizure Disorder	Yes	No
Stroke / TIA / Paralysis	Yes	No
Kidney disease / Dialysis	Yes	No
Bleeding or clotting (blood) disorders	Yes	No
Ie. VonWillebrands or Factor V Leiden		
Hepatitis / other liver disease	Yes	No
Severe arthritis	Yes	No
Hypo or Hyperthyroid	Yes	No
Tuberculosis / positive TB test	Yes	No
Psychiatric / emotional disorder	Yes	No
Cancer Site ________________________________		
❑ Radiation ❑ Chemo		
History of MRSA or ORSA	Yes	No

Name:___________________________

If you have been tested for HIV: ❑ Negative ❑ Positive ❑ Never tested

Do you currently smoke cigarettes/cigars? ❑ No ❑ Yes If YES, how many per day________

How often do you drink alcoholic beverages?____________ How many ________________

Do you use recreational/street drugs? ❑ No ❑ Yes What drugs?_______________________ How often?___________

Do you have problems with balance, falling or need assistance with walking? ❑ No ❑ Yes
Do you use: walker❑ cane ❑ wheel chair❑ ?
Have you accidentally fallen in the past year which required medical care/attention? ❑ No ❑ Yes

List all previous surgeries: ❑ Never had surgery before

____

____

Do you have difficulty turning your head or neck? ❑ No ❑ YES, EXPLAIN____

Has an Anesthesiologist told you that you have a **difficult airway**? ❑ No ❑ YES,
EXPLAIN____

____

Have **YOU** or any **BLOOD RELATIVE** had any problems connected with anesthesia or operations, such as malignant hyperthermia? ❑ No ❑ YES please specify including when, where and the type of reaction: ______________________________

____

Have **YOU** or any **BLOOD RELATIVE** had a history of unexplained and unanticipated high fever either during or within the first several hours following surgery or during exercise? ❑ No ❑ Yes, explain: ______________________________________

Have **YOU** or any **BLOOD RELATIVE** had a history of a muscle or neuromuscular disorder (for example muscle weakness or serious muscle cramps) ❑ No ❑ Yes, explain: ____

Have you been hospitalized for any reason in the past year: ❑ No ❑ Yes
If YES, please specify: ____

Name of the responsible adult who will drive & stay with you for 24 hours after your surgery: _________________________

For Females: Date of your last menstrual period: _____________Are you pregnant or suspect that you might be?❑ **No** ❑ **Yes**

Pediatric Patients need to bring current **Immunization Record** day of surgery, or have pediatrician fax it to us. 267-8256

Do you have any concerns or special problems that we should be aware of? ❑ No ❑ Yes, ___________________________

____ ____________________________

Signature of patient or responsible party Date

____

Relationship to patient (if not signed by patient)

DO NOT WRITE BELOW THIS LINE

____

____

Reviewed Health History by: ____ Date: ____________________

❑ Medications for day of surgery and health history were reviewed with patient

Last Oral Intake: Date: ________________ Time: _________ / ❑ Sip of water with morning medication day of surgery

Comprehensive Health History Completed by:_______________________________________ Date: ___________________

Name:_____________________________

Family History: Please check all that apply.

Disease	Mother	Father	Mother's Parents	Father's Parents	Siblings	Children
Heart Disease						
High Blood						
Cancer – what						
Respiratory						
Glaucoma						
Diabetes						
Bleeding/Clotting Disorder						
Thyroid Disease						
Mental Illness						
OTHER						

Review of Systems: Please circle if you are experiencing any of the following:

Eyes: cataracts, glaucoma, vision loss, blurry vision, double vision – Do you wear glasses or contacts? ______________

Ears: hearing loss, ringing in the ears, dizziness or balance problems, ear pain, drainage – Do you wear hearing aids? ________

Nose and Sinus: nasal blockage, nose bleeds, frequent sinus infections, post nasal drip, hay fever, allergies

Speaking and swallowing: difficulty chewing or swallowing, problems speaking, hoarseness, pain

Respiratory: shortness of breath, wheezing, cough, asthma – Do you require oxygen? _________

Cardiac: chest pain, enlarged heart, murmur, irregular heartbeat, pacemaker

Gastrointestinal: bleeding ulcer, hiatal hernia, abdominal pain, diarrhea, diverticulitis, polyps, hemorrhoids, changes in weight

Kidney/Bladder: frequent urination, burning, blood in urine, kidney stones, enlarged prostate

Neurological: migraines, numbness, tingling, weakness, seizures, hx of Bell's palsy, paralysis

Vascular: varicose veins, hx of blood clots, calf pain when walking

Hematological/Lymphatic: anemia, bleeding problems, easy bruising, swollen nodes, lymphedema, hx of clotting problems

Skin: rash, frequent itching, sores that won't heal, infections or boils, skin lesions

Endocrine: thyroid problems, weight loss or gain, excessive sweating, tremor

MEDICATIONS CONTINUED:

Medication	**Dose**	**Frequency**	**Route**	**Last Taken** (to be complete by preoperative nurse day of surgery)

Consent to Share Photographs & Contact Information

Patients often find that speaking to others who have shared similar experiences and viewing before and after pictures can be helpful when deciding about having surgery or a particular treatment. To this end, we ask our patients to consider sharing their experiences as a way of helping others. Even if you do not wish to share your photos, being available as a resource is also very valuable. Thank you for your consideration.

Please indicate your preferences by initialing all that apply.

<u>Use of Patient Photographs</u>

I **give consent** to Vega Plastic Surgery & Med Spa to use my photographs for the following purposes:

____ Marketing for Vega Plastic Surgery & Med Spa (e.g. websites)

____ Staff educational purposes (e.g. internal office conferences, meetings, presentations)

____ Patient educational purposes <u>outside our office</u> (e.g. community seminars or meetings)

____ Patient educational purposes <u>in our office</u> (e.g. patients considering a similar surgery, procedure or treatment)

____ TouchMD for patient education purposes (Photo gallery - only visible to Vega Plastic Surgery patients)

___ I **DO NOT give consent** to Vega Plastic Surgery & Med SPA to utilize my photographs for any reason

<u>Sharing Patient Contact Information</u>

____ I **give consent** for Vega Plastic Surgery & Med Spa to share my contact information with other patients. I am willing to discuss my surgical experience or aesthetic treatment with those interested in similar procedures.

____ **I DO NOT give consent** to Vega Plastic Surgery & Med Spa to share my contact information with other patients

I understand that I may revoke my consent at any time in writing except to the extent that the practice has already made disclosures or published photographs in reliance upon my prior consent.

Print Name____________________________________

Signature______________________________________ Date____________