PATIENT INFORMATION

DATE:_____ SS#:_____

NAME:_____
LAST FIRST MIDDLE

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE_____

DOB:_____/_____/_____ AGE:_____ MARITAL STATUS: M S D W SEP

Primary contact #: ( )_____ Is this: Home Cell Work Other:_____
May we leave a detailed message at this number? Yes No

Secondary contact #: ( )_____ Is this: Home Cell Work Other:_____
May we leave a detailed message at this number? Yes No

Email address: _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED:_____

PHONE:_____RELATIONSHIP:_____

PATIENT EMPLOYER INFORMATION

PATIENT EMPLOYED BY:_____

OCCUPATION:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PHONE:_____ May we leave a detailed message at this number? Yes No

HOW DID YOU FIND OUT ABOUT US:

□ □Phone book □Previous Patient(please list below) □□Physician(please list below)

□ Google □ Yahoo □□loveyourlook.com

□Internet (other) _____(please list source)

PLEASE LIST REFERRAL NAME/LOCATION:_____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ♦Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment either directly or indirectly.
- ♦obtain payment from third-party payers including credit card companies, finance companies or banks
- ♦conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the opportunity review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ DATE: _____
Signature of patient

I understand the procedure that I am requesting is cosmetic in nature and understand that Dr. Straka will not submit any claims to any insurance company for coverage of this procedure and understand that Dr. Straka will not accept insurance for this procedure. I understand that I am responsible for all fees and that all surgical fees are due prior to surgery being performed.

_____ DATE: _____
Signature of patient

Please list those people with whom we may discuss/release medical information to:

_____

_____

To my patients;

I am occasionally asked to review cases and treat patients who have less than satisfactory results from other surgeons. It is my pleasure to try to correct these unsatisfactory results, but I must advise all of my patients that I will **not** testify as an expert witness in any legal proceedings whether for a plaintiff's attorney or a defendant's attorney. My schedule is too demanding and it takes away from my focus of providing the best medical care possible.

Patient signature:_____

Health History

Patient Name: _____ Date: _____

Age: _____ Birthdate: _____/_____/_____ Height_____ Weight _____

What is the reason for your visit today?_____

Allergies: Are you allergic to any medications? _____Yes _____No
If yes, please list medication(s) and type of reaction(s): _____

_____

Latex allergy: _____Yes _____No **Sensitivity to adhesive tape:** _____Yes _____No

Medications: _____ Yes _____ No If yes, please list all medications you are currently taking including herbal medicines, diet pills, vitamins, supplements and over-the-counter medications:_____

_____

_____

Hospitalizations and/or previous surgeries: _____Yes _____No If yes, please list with dates and hospital where surgery was performed:

_____

_____

Do you use tobacco or nicotine products: _____Yes _____No If yes, which product, how frequent and for how long have you used this product? _____

Have you or an immediate family member ever been diagnosed with a STAPH (MRSA) infection?

_____Yes _____No If yes, who/when:_____

Are you currently under the care of a physician(s): _____Yes _____No If yes, please list name of physician(s), phone number(s) and what you are being treated for:_____

_____

Who is your primary care physician/phone number? _____

Are you now or have you been under the care of a psychiatrist/therapist within the past 2 years:

_____Yes _____No If yes, for what:_____

Cardiovascular: (any personal history of the following)

High Blood Pressure	_____Yes	_____No
Coronary Artery disease	_____Yes	_____No
Angina/chest pain	_____Yes	_____No
Prior heart attack	_____Yes	_____No
Heart valve disease	_____Yes	_____No
Heart rhythm problems and/or pacemaker	_____Yes	_____No
Elevated cholesterol	_____Yes	_____No
DVT (Deep vein thrombosis)	_____Yes	_____No
Pulmonary Embolism	_____Yes	_____No
Mitral valve prolapse	_____Yes	_____No
Heart Murmur	_____Yes	_____No
Do you have a cardiologist?	_____Yes	_____No

If yes,who?/where?_____

Previous cardiac tests? (EKG, ECHO, stress test, etc.) ____Yes ____No
If yes, what/when? _____

_____

Sickle Cell disease or trait? _____Yes _____No

Other heart disease: _____

Endocrine:

Diabetes _____Yes _____No
If yes, on insulin _____Yes _____No
Thyroid disease _____Yes _____No

Renal:

Kidney problems _____Yes _____No
Kidney stones _____Yes _____No
Dark or chocolate colored urine _____Yes _____No

Gastrointestinal:

Do you drink alcohol? _____Yes _____No
If yes, how much/how often: _____
History of Hepatitis/liver problems _____Yes _____No
History of Ulcers _____Yes _____No
History of Acid Reflux _____Yes _____No
History of Blood Transfusions _____Yes _____No
Hiatal Hernia _____Yes _____No
Mononucleosis in the past 6 months _____Yes _____No

Pulmonary:

Asthma _____Yes _____No
If yes, ever required any steroids? _____Yes _____No
COPD/ Bronchitis/ Emphysema _____Yes _____No
Sleep Apnea _____Yes _____No
Sleep Study performed _____Yes _____No When and where:_____
Do you use a CPAP device/mask? _____Yes _____No
Name/number of treating doctor:_____
Recent respiratory illnesses _____Yes _____No
Difficulty climbing two flights of stairs _____Yes _____No

Neuro:

History of Loss of Consciousness _____Yes _____No
Stroke _____Yes _____No
Seizures _____Yes _____No
Peripheral Neuropathy _____Yes _____No
(numbness/weakness/shooting pains in limbs)
Back or neck trouble _____Yes _____No

Airway:

Caps/Crowns _____Yes _____No
Dentures or bridges _____Yes _____No
Loose or chipped teeth _____Yes _____No
TMJ syndrome _____Yes _____No
Neck/Cervical spine problems _____Yes _____No
History of previous difficult intubation _____Yes _____No
Has a dentist ever told you that you have difficult/limited access to your teeth due to your airway anatomy?
____Yes _____No

General:

Do you have any blood disorders _____Yes _____No
History of prolonged bleeding _____Yes _____No
Large scars or keloids _____Yes _____No
Skin Diseases _____Yes _____No
Cancer _____Yes _____No If yes, what type:_____

_____

Any other illness not listed above?:_____

_____

Anesthesia:

Any previous general anesthetic complications? _____Yes _____No
If yes, what was your reaction?

_____

_____

History of motion sickness? _____Yes _____No
Family members with anesthetic complications? _____Yes _____No
If yes, what was the reaction: _____

_____

Family history of malignant hyperthermia _____Yes _____No
High fever following strenuous exercise _____Yes _____No

Family History: check (X) if blood relatives have had any of the following.:

Relationship to you

□ Breast cancer _____
□ Keloid scars _____ □ Diabetes _____
□ Bleeding disorders _____ □ Heart disease/stroke _____
□ Prolonged Bleeding _____ □ PE (Pulmonary Embolism)_____
□ DVT (Deep vein thrombosis) _____
□Other:_____

Please explain any yes answers here, if not already explained above:

_____
_____
_____
_____
_____

_____ Date: _____
Patient Signature

_____ Date: _____
Philip J. Straka, M.D.

_____ Date: _____
Anesthesiologist