PATIENT INFORMATION FORM

Patient Name: ______________________________________ Sex: ☐ Female ☐ Male

Mailing Address: ______________________________ City: ____________ State: _____ Zip Code: _________

Social Security #: ___________________ DOB: ___________________

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 (Circle One)

☐ AFPS Website ☐ Postcard/Flyer ☐ Magazine

☐ Referral: _____________ ☐ Patient: _________ ☐ Other: ____________________

What are your primary cosmetic goals / concerns? ____

____

What is your budget? ___________________________ **Is surgery an option?** __________________________

Please list previous surgical operations, including procedures done for cosmetic reasons:

Procedure:		**Date:**	
Procedure:		**Date:**	
Procedure:		**Date:**	
Procedure:		**Date:**	

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

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)*

____

____

____

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 #: ___________________

1810 116th Ave, NE, Ste 102, Bellevue, WA 98004 | 425.990.FACE (3223) | fax 425.990.3225 | YoungVitalizer.com

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's Name: ____

Patient's signature: ____ Date: ____________________________