

WELCOME TO OUR OFFICE

Today's visit will give you the opportunity to gather and exchange information necessary to make important decisions about your appearance. The successful outcome we both seek will be enhanced by your willingness to join us in a mutually responsible partnership. We will be with you all the way – sharing our skills and genuine concern about you and your ultimate result. Every member of our medical and support team is dedicated to optimizing your overall experience, safety, comfort and of course, anonymity.

Date: ____/____/____ Patient Name: _____ Date of Birth: ____/____/____

Age: _____ Gender: F M Height: _____ Weight: _____ Social Security Number: _____

Address: _____ City: _____ Zip: _____

Home Telephone: _____ Cell: _____ Work: _____ Preferred Contact: Home Cell Work

Email: _____ Who Referred You? _____

Occupation: _____ Married Single Spouse: _____

Emergency Contact: _____ Telephone: _____ Relationship: _____

Do we have your permission to communicate information regarding your care/treatments via email? Yes No

Would you like to receive email communications regarding our monthly specials? Yes No

My consultation today is for: _____

SURGICAL HISTORY (MEDICAL AND COSMETIC)

Procedure	Date	Complications or Difficulties

MEDICAL INFORMATION

Physician name and address: _____ Date of last physical exam: _____

Medical problems or conditions: _____

RELEASE OF INFORMATION

Who are we authorized to speak to regarding your medical information?

Name: _____ Telephone: _____ Relationship: _____

Name: _____ Telephone: _____ Relationship: _____

Name: _____ Telephone: _____ Relationship: _____

MEDICAL HISTORY

Are you now taking any drugs or medications? If yes, please list name and frequency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you allergic to any medication, cream, tape, make-up, etc.? If yes, please list	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever received local anesthesia (Novocaine, Xylocaine) by a dentist or doctor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you have an adverse reaction to any anesthesia? If yes, please explain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you or a family member have: (indicate who) Heart Trouble _____ Excessive Bleeding _____ High Blood Pressure _____ Diabetes _____ Thyroid Problems _____ Psychiatric or "nerve" problems _____ Excessive Bruising _____ Excessive Scarring _____ Delayed or Poor Healing _____ Other _____		
Do you have any history of bleeding? (Indicate which) From the Nose _____ In the Urine _____ Vomiting Blood _____ From the Rectum _____ Cough Up Blood _____ Other _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have or have you had nasal allergies, sinus problems, asthma or hay fever? (Explain) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have stomach trouble? Ulcers? (Explain) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have or have you had chest or lung problems? (Explain) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had liver, gall bladder trouble or yellow Jaundice? (Explain) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been bothered by kidney or bladder problems? (Explain) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have frequent skin infections, irritation or rashes? (Explain) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had fever blisters, cold sores or canker sores on your face, lips or mouth or Genital Herpes (Explain) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you often have severe headaches or dizzy spells? (Explain) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has any part of your body ever been paralyzed or numb? (Explain) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you ever have a convulsion or seizure? (Explain) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Were you ever told you had any venereal disease or AIDS? (Explain) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Were you ever treated for anemia or any problems with your blood? (Explain) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you Smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you drink two or more alcohol drinks per day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever received treatment for abuse of alcohol or drugs? (Explain) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you often get depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever received medical treatment for a nervous breakdown? (Explain) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been under the care of a psychiatrist or psychologist? (Explain) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any other medical problems that have not been covered? (Explain) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you accept the fact that every medical and surgical treatment is associated with risks and imponderables? (Explain) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I certify that the above information represents my complete and accurate medical history. I will not hold Dr. Tzikas or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form. I acknowledge that I have received the Notice of Privacy Practices.

Patient/Guardian Signature: _____ Date: _____