Aesthetic Origins

New Patient Information Sheet

Today's Date____________________________

Patient's Name____
Address____
City______________________________ State__________ Zip Code___________________
Home Phone___________________ Work Phone___________________ Cell Phone________________
Date of Birth_____________________ Age (optional)____________ Sex _____________
Marital Status: S_____ M______ Div______ W______
Patient Employer____
Position____
Spouse Name_______________________________________Employer____________________________
In Case of Emergency Call______________________________________ Phone____________________
Relationship____
Name of Internist/Gynecologist____
Name of Dermatologist____
Is it important to you that treatments are done in a medical setting? Yes______ No______
Why?____

WHAT SERVICES ARE YOU INTERESTED IN?

___ Peels
___ Skin Care Products
___ Facials/Deep Pore Cleansing
___ Acne Treatment
___ Microdermabrasion
___ Collagen
___ Botox
___ Other____
___ Consultation with Physician
___ Comprehensive Vein Therapy
___ FotoFacial
___ Laser Hair Removal
___ Make-up/Makeovers
___ Permanent Make-up

HOW WERE YOU REFERRED TO *AESTHETIC ORIGINS*?

Physician____
Mailer/Postcard______________________________ Staff____________________________________
Patient Name______________________________ Friend/Name__________________________
Newspaper_______________________ Other___________________ Event______________________
Radio____
Yellow Pages________________ Gift Certificate____
Seminar____
Biomedic Co.__________________________ Department Store________________________________
Walk-in_____________________________ Reputation_______________________________
Web____

FOR CLINIC USE ONLY: **Site**____________________________

Specialist______________________________________ Treatment______________________________
Last Name______________________________________ First__________________________________
Date of next appt_________________________________

MEDICAL HISTORY

Name:____ Age:_____ Sex:_____ Date:__________________________

1. Do you have a history of:
   a. Systemic or discoid lupus erythematosus ___Yes ___No
   b. Rheumatoid arthritis ___Yes ___No
   c. Polyarteritis nodosa ___Yes ___No
   d. Hashimoto's disease ___Yes ___No
   e. Graves' disease ___Yes ___No
   f. Progressive systemic sclerosis (scleroderma) ___Yes ___No
   g. Dermatomyositis ___Yes ___No
   h. Mixed connective tissue disease ___ Yes ___No
   i. Ulcerative colitis ___Yes ___No
   j. Crohn's disease ___Yes ___No
   k. Sjorgren's syndrome ___Yes ___No
   l. Reiter's syndrome ___Yes ___No
   m. Mixed connective tissue disease ___Yes ___No
2. Do you have a history of:
   a. Undiagnosed arthralgia or frequent episodes of swelling, heat or tenderness in any joint(s) ___Yes ___No
   b. Asthma ___Yes ___No
   c. Eczema, skin changes ___Yes ___No
   d. Hay fever ___Yes ___No
   e. Anaphylactic reactions ___Yes ___No
   f. Previous episodes of itchy skin reactions or rashes ___Yes ___No
   g. Hepatits? ___Yes ___No
   h. Herpes? ___Yes ___No
   i. High blood pressure? ___Yes ___No
   j. Heart trouble or an irregular heart beat? ___Yes ___No
   k. Have you ever had keloids or bad scarring after surgery? ___Yes ___No
   l. Allergy to caine derivatives (Lidocaine, Novocain, Xylocaine) ___Yes ___No
   m. Allergy to beef ___Yes ___No
   n. Allergy to other substances (please specify):
      1.____
      2.____
      3.____
   o. Thin skin ___Yes ___No
   p. Sensitive skin ___Yes ___No

   If so, please describe____
3. Have you ever had a bad reaction to a local anesthetic? ___Yes ___No
   To any anesthetic? ___Yes ___No
4. Have you ever had a bad reaction to a dental shot? ___Yes ___No
5. Do you have problems with fainting? ___Yes ___No
6. Do you bleed excessively after minor surgery or dental procedures? ___Yes ___No
7. Do you have HIV, AIDS or have you been exposed to AIDS? ___Yes ___No
8. Have you ever had any treated mental illness? ___Yes ___No
9. Are you using any of the following:
   a. Anti-inflammatory drugs (Aspirin, Motrin, Indocin, etc.) ___Yes ___No
   b. Antihistamines ___Yes ___No
   c. Immunosuppressives (Imuran, etc.) including radiotherapy ___Yes ___No
   d. Desensitizing allergy injections ___Yes ___No
   e. Cortisone ___Yes ___No
   f. Aspirin or blood thinners ___Yes ___No
   g. Antibuse or Flagel ___Yes ___No
   h. Antibiotics ___Yes ___No
   i. St. John's Wort ___Yes ___No
   j. Smoke, alcohol or drugs ___Yes ___No
      How much?_____________________ How frequently?____
   k. Other (please specify)
      ____
10. What are your current medications?____
    ____
11. Do you have any illnesses which have prevented you from having minor surgery in the past? ___Yes ___No
    If yes, please explain:____
12. Are you now or have you recently been treated for health problems?____
    ____
    What?____ When/Whom____
13. Have you had skin cancer? ___Yes ___No
    What kind:____ Where on the body:_____________________________________
14. Are you pregnant? ___Yes ___No Number of pregnancies:______________________________
15. Are you nursing? ___Yes ___No

16. Previous chemical peel or dermabrasion? ___Yes ___No
    ___Phenol ___Alpha-hydroxy (glycolic)
    ___TCA
    Other____
    When?____
    Where?____
17. X-ray Treatment of Face and/or Neck for Acne? ___Yes ___No
18. Have you ever taken Accutane? ___Yes ___No Date:____________________
    finished:____________________________
19. Facial Cosmetic Surgery? ___Yes ___No Date:____________________
    Any residual numbness? ___Yes ___No
    Where?____
20. Do you wear contact lenses? ___Yes ___No

SKIN EVALUATION

How would you describe your skin type and color?

___normal ___fair ___Olive
___dry ___medium ___Asian
___oily ___dark ___American Indian
___combination ___Black

Does your skin burn in the sun?

___Only the 1st time of the season ___Always __Rarely ___Sometimes ___Never

Have you had acne? ___Yes ___No

___Minor ___Major ___Cystic

List how you care for your skin and the names of the products you are currently using:

MORNING EVENING

What changes would you like to see in your skin?

How soon do you expect to see noticeable results?

___Immediately ___within a few weeks ___over a period of months

What is your level of commitment? Are you willing to spend:

___ a little time and effort. ___a moderate amount of time and effort. ___a good deal of time and effort
.

What are you willing to tolerate?

___temporary light skin flaking. ___temporary redness, irritation. ___temporary facial scabbing.

IF YOU ARE HAVING PERMANENT MAKE-UP, PLEASE COMPLETE THE FOLLOWING:

Have you had permanent cosmetics in the past? ___Yes ___No

If yes, how long ago?____________________ Were you happy with the results? ___Yes ___No

How many applications did it take to achieve the results?____________________

Did the color change? ___Yes ___No

Are you allergic to any color cosmetics, such as eyeliner? ___Yes ___No

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received the ***Notice of Privacy Policies*** established for Denver Plastic Surgery Associates.

____________________________________ ________________________

Patient Signature Date

DOCUMENTATION OF GOOD FAITH EFFORTS TO OBTAIN PATIENT'S ACKNOWLEDGEMENT THAT THEY HAVE RECEIVED PROVIDER'S NOTICE OF PRIVACY PRACTICES

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For use when acknowledgement cannot be obtained from the patient.

This patient presented to our office on _____________________and was provided with a copy of our ***Notice of Privacy Policies***. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign
- ☐ Patient was unable to sign or initial because:

____

____

- ☐ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.
- ☐ Other reason:

____

____

______________________________________ ____________________________

Signature of Employee Date