Patient Information & Medical History

This Patient Information and Medical History is accurate as of today's date: ___________________________
(Please print legibly & fill in all fields. If not available, please put N/A)

Personal Information:

Patient Name __________________________________ DOB ________________________ Age ________

Address ____ Apt# ________________

City ____ State ________________________ Zip ________________

C. Phone (____)____________________ H. Phone (____)__________________W. Phone (____)________________

Email Address ________________________ How may we contact you? ❐Cell ❐Home ❐Work ❐Email

Occupation ____________________ Employer ____________________________________

Preferred Language ____________________________ Sex: € Male € Female

Emergency Contact Name/Phone Number ____________________________ # (_____)________________________

Reason for your visit today?____

How did you find out about us?____

Is your general health good? € Yes € No Height _______ Weight _______

Date of last physical ________ EKG _______ Chest X-Ray ________ Primary Physician ____________________

Have you ever been under the care of a cardiologist? ❐Yes ❐No If yes, who? ________________________

Allergies? € Yes € No Known Drug Allergies Food/Environmental Allergies? ❐ Yes ❐ No

If yes, list what, reaction, and severity ____

List all medications you are taking (prescription, supplements, vitamins, and herbals), Dose and how often:

____

____

____

Do you take Aspirin, Advil, Motrin, Ibuprofen, or anti-inflammatory medication more than once per week?

€ Yes € No If yes, please explain: ____

Do you smoke, Vape, or use nicotine? € Yes € No If yes, how many per day/for how many years: ____________

Do you use recreational drugs? ❐Yes ❐No If yes, what and how often:_________________________________

Do you drink alcohol? € Yes € No If yes, how much/how often: _______________________________________

Are you using a Tretinoin? ❒Yes ❒ No Do you wear sunscreen? ❒Yes ❒No Date of last sun exposure_________

Patient (or legal representative) Signature:____________________________________ Date:________________

Present/Past Medical History:
Have you ever had any of the following (please check all that apply):

€ Asthma
€ Autoimmune disorder
€ Chronic diarrhea
€ Diabetes
€ Excessive scarring
€ Heart valve disease
€ High/low blood pressure
€ Irregular heart beat, PVC
€ Kidney disease, issues
€ Multiple Sclerosis
€ Migraines
€ Seizures
€ Skin cancer or precancer
€ Thyroid disorders
€ Hepatitis
€ Herpes
€ Arthritis
€ Blood disorder
€ Clotting disorder
€ Depression
€ Excessive bleeding
€ Heart valve or stent
€ Hepatitis
€ Intestinal problems IBS, IBD
€ Liver problems
€ Muscular Dystrophy
€ Radiation/Chemo
€ Upper GI problems
€ Sleep Apnea (CPAP?)
€ Emotional problems
€ Eye or vision issues
€ Cancer: Please list type: ____________________________________
€ Anemia
€ Chest pain
€ Colon problems
€ Bruise easily
€ Heart attack or MI
€ Hernia or repair
€ HIV or AIDS
€ Keloids
€ Lung disease, COPD
€ MVP
€ Shortness of breath
€ Varicose veins/DVT
€ Stroke
€ Psychiatric problems
€ Autoimmune Disorders
€ Other not on list above:____
____

List all surgeries or hospitalizations with dates:
____ Date____________________________
____ Date____________________________
____ Date____________________________
____ Date____________________________

Have you or a family member ever had a problem with any form of anesthesia?
If yes, please explain:____

You or family member ever suspected of having Malignant Hyperthermia? ❒Yes ❒No

Have you ever been told you are difficult to intubate? ❒Yes ❒No

Please list any Cosmetic Procedures you have had (surgical and non-surgical, injectables, laser/devices) with dates:
____ Date____________________________
____ Date____________________________
____ Date____________________________
____ Date____________________________

Have you ever had difficulties with numbing cream/gel (Lidocaine, Tetracaine, Benzocaine) ❒Yes ❒No

Please describe your current skin care process:____
____

Female patients, please complete:
Are you currently pregnant or trying to become pregnant? € Yes € No Are you breastfeeding? € Yes € No

How many times have you been pregnant? _____ Number of children? _____

Date of: Last menstrual cycle __________ Mammogram _________ Bra size ______ (consult for breast surgery)

Patient (or legal representative) Signature: ____________________________________ Date:________________

Medical Privacy Authorization for Release of Information

Lyle Plastic Surgery and Aesthetics Center takes our patient privacy very seriously. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we can only discuss your health care and treatment as well as account information with you personally, or your legal guardian if a minor.

If you would like us to be able to discuss your health information with anyone else (i.e. spouse, children, significant other, caregiver, or someone financially responsible for your account, etc.) please indicate this person(s) below.

We will not be able to discuss your information with anyone other than those you have indicated below.

Name	Relationship	Contact Info

This area below is provided for any specific or further information you may wish to give.

Patient (or legal representative) Signature: ______________________________ Date:______________

AUTHORIZATION AND ASSIGNMENT

I hereby authorize Lyle Plastic Surgery and Aesthetics Center, PLLC to furnish all necessary information to appropriate parties such as insurance carriers, physicians, and attorneys concerning treatment rendered. I understand that I am responsible for ALL medical expenses whether or not there is insurance coverage (and0or ANY expenses incurred as a result of collecting a past due account). I understand that payment for office visits are due the day of service and if insurance is submitted for surgical services is not paid by 60 days, I must pay in full unless arrangements are made. I consent to be photographed and understand that the photographs are necessary for my treatment and /or determination of insurance benefit or legal reasoning. The photographs will not be used for advertising or marketing purposes.

Patient (or legal representative) Signature: ________________________________ Date: _______________

To the best of my knowledge, the information provided above is true and accurate.
I agree to tell the staff of any changes to my health history or medications as they arise.
I understand that information is necessary for your practice and will remain confidential.
All efforts are routinely made to ensure privacy is upheld.

Printed Patient Name	**Date**	**Signature of Patient**
Printed Legal Guardian Name	**Date**	**Signature of Legal Guardian (if Patient is a Minor)**
Practice Representative Name		**Signature of Practice Representative**