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www.oculoplastic.info

Date: _____

Name: _____ Age: _____ DOB: ____/____/____

Address: _____ Home Tel: (____) _____

City _____ Zip _____ Wk Tel: (____) _____

Email: _____ Cell: (____) _____

Referring Physician: _____ SS# _____

How did you hear about Dr. Parsa? _____

Have you been to our website? _____ Was our website helpful? No Yes If No, pls. list reason:

What is the reason for your visit today? (Circle all applicable procedures below)

Cosmetic Surgery	Reconstructive Surgery	MediSpa
Cosmetic Eyelid Surgery Revisional Eyelid Surgery Brow Lift or rejuvenation Cheek Lift or augmentation Facial Implants Fat Transfer Lip Augmentation Other _____ Other _____ Other _____	Ptosis (droopy eyelids) Revisional Ptosis Surgery Customized Orbitofacial Reconstruction Orbital Fractures Facial Paralysis Thyroid Eye disease Eyelid Malposition Eyelid Reconstruction Tearing Other _____ Other _____ Other _____ Other _____	Botox® Restylane® Perlane® Juvéderm® Radiesse® Enzyme Peel Laser Hair Removal Skin Tightening Laser Photo Facial Pixel Treatment Cellulite Treatment Vein Treatment Other _____

Please describe why you are interested in having the procedure(s) listed above: _____

Have you consulted with other physicians about procedure(s) indicated above: No Yes

If Yes, please describe your understanding of the procedure(s) _____

Is this procedure a revision from a previous surgery No Yes If yes, how many previous surgeries? _____

What is your "ideal time frame" for procedure(s) completion _____

Age _____ Weight _____ Height _____ B/P _____ (taken in office)

Employer _____ Address _____

Occupation: _____ Marital Status: _____

Primary Insurance Co. _____ Policy # _____

Group # _____ Name of person insured _____ SS# _____

Eligibility Phone # _____ Copay _____

Secondary Insurance Co. _____ Policy # _____

Group # _____ Name of person insured _____ SS# _____

Eligibility Phone # _____ Copay _____

HEALTH INFORMATON

Personal Past History:

Do you have any chronic medical problems? (Circle all that apply)

- | | | |
|---------------------|-----------------------|------------------|
| High Blood Pressure | Diabetes | Cancer |
| Heart Disease | Kidney Disease | HIV or AIDS |
| Heart Failure | Psychiatric Diagnosis | Stroke |
| Seizures | Bleeding Problems | Hepatitis |
| Heart Attack | Liver Disease | Emphysema |
| Chest Pain | Gastric Reflux | Stomach Problems |
| | Asthma | Other _____ |

Is there a personal or family history of anesthetic complications? No Yes

If yes, please explain _____

Family History:

Do you have a family history of any medical problems? (Circle all that apply) Please indicate family member.

- | | | |
|---------------------|-----------------------|------------------|
| High Blood Pressure | Diabetes | Cancer |
| Heart Disease | Kidney Disease | HIV or AIDS |
| Heart Failure | Psychiatric Diagnosis | Stroke |
| Seizures | Bleeding Problems | Hepatitis |
| Heart Attack | Liver Disease | Emphysema |
| Chest Pain | Gastric Reflux | Stomach Problems |
| | Asthma | Other _____ |

Please list all prior operations:

Date

List any complications

- | | | |
|----------|-------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |
| 6. _____ | _____ | _____ |

Please list all prior Hospitalizations:

Date

List any complications

1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Please list **ALL** medications and/or dietary supplements including:

(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

Please list **ALL** allergies and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc).

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Social History:

Have you ever used tobacco products? No Yes If yes, how long?_____ how much?_____

Which tobacco product(s) have you used?_____

If you are a former smoker, state the year you stopped: _____

Past or current use of Nicotine Gum, Patch, or any other type of stop-smoking aid: No Yes

If yes, please list: _____

Alcohol Consumption: _____Never (Do not consume alcohol) _____ Rare (1-2 drinks a week)

_____ Moderate (7-10 drinks a week) _____ Heavy (daily or more than 10 drinks a wk)

Did you ever drink heavily in the past? No Yes

Are you feeling hopeless about the present/future? No Yes

Do you currently have thoughts of harming yourself? No Yes

Review of Systems:

Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR

High Blood Pressure Y ___ N ___
Heart Attack Y ___ N ___
Angina/chest pain Y ___ N ___
Heart bypass surgery Y ___ N ___
Pacemaker Y ___ N ___

Heart Failure Y ___ N ___
Irregular Heartbeat Y ___ N ___
Heart Murmur Y ___ N ___
Do you exercise? Y ___ N ___
Comments: _____

NEUROLOGICAL

Stroke Y ___ N ___
Seizures Y ___ N ___
Fainting Y ___ N ___
Dizziness Y ___ N ___
Headache Y ___ N ___
Double Vision Y ___ N ___

RESPIRATORY

Abnormal Chest X-ray Y ___ N ___
Asthma Y ___ N ___
Bronchitis Y ___ N ___
Emphysema Y ___ N ___
Recent Chest Infection Y ___ N ___
Shortness of Breath Y ___ N ___
Shortness of Breath at night Y ___ N ___
Shortness of Breath on exertion Y ___ N ___
Cough Y ___ N ___
Cough with Sputum Y ___ N ___
Sleep Apnea Y ___ N ___
-Use a C-PAP Machine Y ___ N ___

PSYCHIATRIC

Depression Y ___ N ___
Anxiety Y ___ N ___
Psychiatric Care Y ___ N ___
Obsessive Compulsive Disorder Y ___ N ___

ENDOCRINE

Diabetes Y ___ N ___
Thyroid Disease Y ___ N ___
Taken Steroids Y ___ N ___

MUSCULOSKELETAL

Sciatica Y ___ N ___
Herniated disc Y ___ N ___
Arthritis Y ___ N ___
Rheumatoid Y ___ N ___
Neck, Back, Arm, Leg Prob Y ___ N ___

HEMATOLOGIC/ONCOLOGIC/

Bleeding Tendency Y ___ N ___
Easy Bruising Y ___ N ___
Anemia Y ___ N ___
Sickle Cell Disease Y ___ N ___
Blood clots in legs Y ___ N ___
Blood clots in lungs Y ___ N ___
Radiation Therapy Y ___ N ___

INFECTIOUS

GASTROINTESTINAL

Jaundice Y ___ N ___
Hepatitis Y ___ N ___
Ulcers Y ___ N ___
Hiatal Hernia Y ___ N ___
Heartburn Y ___ N ___

URINARY/REPRODUCTIVE

Kidney Disease Y ___ N ___
Urinary Disease Y ___ N ___
Dialysis Y ___ N ___
If Female, could you be preg? Y ___ N ___
Number of live births _____
Number of pregnancies _____
Date of last mammogram _____
Date of date of menses (period) _____

SKIN

Basal cell skin cancer Y ___ N ___
Melanoma Y ___ N ___
Staph Infection Y ___ N ___

EYES

Cataracts Y ___ N ___
Glaucoma Y ___ N ___

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Kami Parsa, M.D., Professional Corporation, all Medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. If the nature of the disability be such that it is not covered by insurance, I will be responsible to the doctor for payment of the entire bill. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Date

Patient's Signature

Date