KAMI PARSA M.D.
OCULOPLASTIC SURGERY
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Mr.◯ Mrs.◯ Ms.◯ Dr.◯ Date: _____

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

Address: _____City_____State_____ Zip_____

Home Tel: _____Cell:_____Wk Tel: _____

Email: _____ SS# _____

Primary Physician: _____ Phone #_____

How did you hear about Dr. Parsa ?_____

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

_____

Is it ok to send mail to your address:◯No◯Yes Email Blast:◯No◯Yes Leave messages on #'s above:◯No◯Yes

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

Cosmetic	Functional	MediSpa
☐ Cosmetic Eyelid Surgery	☐ Ptosis (droopy eyelids)	☐ Botox®
☐ Revisional Eyelid Surgery	☐ Revisional Ptosis Surgery	☐ Restylane®
☐ Brow Lift or rejuvenation	☐ Customized Orbitofacial Reconstruction	☐ Perlane®
☐ Cheek Lift or augmentation	☐ Orbital Fractures	☐ Juvéderm®
☐ Facial Implants	☐ Facial Paralysis	☐ Radiesse®
☐ Fat Transfer	☐ Thyroid Eye disease	☐ Pixel Treatment
☐ Lip Augmentation	☐ Eyelid Malposition	☐ PCA Peel
	☐ Eyelid Reconstruction	
	☐ Tearing	
Other_____	Other_____	Other_____
Other_____	Other_____	Other_____
Other_____	Other_____	Other_____

Please describe your visit for today: _____

_____

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

Please list all prior operations:	Date	List any complications
1._____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

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 Failure Y ___ N ____

Heart Attack Y ___ N ____
Angina/chest pain Y ___ N ____
Heart bypass surgery Y ___ N ____
Pacemaker Y ___ N ____

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

PSYCHIATIC
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 ____

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 ____

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)_____

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

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 ____

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

INFECTIOUS
GASTROINTESTINAL
Jaundice Y ___ N ____
Hepatitis Y ___ N ____
Ulcers Y ___ N ____
Hiatal Hernia Y ___ N ____
Heartburn Y ___ N ____

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