BUCKHEAD Facial PLASTIC SURGERY
1218 West Paces Ferry Road NW, Suite 108, Atlanta, GA 30327
phone: 404-233-3937 // fax: 404-261-3996

CONSULTATION & MEDICAL QUESTIONNAIRE

Date: _____

Last Name: _____ First Name: _____ Preferred Name: _____

Marital Status *(circle)*: S M D W Sex: _____ Date of Birth: ___ / ___ / _____ Occupation: _____

Cell: _____ Home: _____ Children's Ages: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ May we add you to our contact list? Yes / No

Referred By: *(fill in the appropriate response)*
Physician: _____
Friend: _____
Family: _____
Magazine: _____
Website: _____
Other: _____

Circle the areas you would like to discuss:

Facelift/Necklift	Vaginal Rejuvenation	Moles, Cysts, etc.	Ultherapy
Nose	Scar Revision	Laser Treatments	CoolSculpting
Browlift	Botox	Microneedling	Skincare
Eyelids	Filler	Hair Reduction	Veins
Liposuction	Sculptra	MiraDry	Hands

Please answer the following questions if you are considering surgery:
What specifically would you like to have corrected? _____
Have you consulted another doctor about this? Yes / No *(if so, whom?)* _____
Have you discussed this with your family? Yes / No
Are they agreeable? Yes / No
Are they willing to help you during recovery? Yes / No
Has anyone close to you had cosmetic or reconstructive surgery? Yes / No
If so, what was done and by whom? _____

Medical History:
Do you take any **PRESCRIPTION** or **OVER THE COUNTER** medications regularly? Yes / No
(please list) _____
Do you take any prescription or over-the-counter medication occasionally? Yes / No
(please list) _____
Do you take vitamins, herbs or minerals? Yes / No *(please list)* _____
_____

Are you allergic to any medications? Yes / No *(please list)*

Medication	What happened when you took this medication?
_____	_____
_____	_____
_____	_____

Are you allergic to any of the following? (*circle*) Eggs/Soap/Adhesive tape/Iodine/Latex/Suture Material
Have you received local anesthesia (Novocaine/Lidocaine) by a dentist or doctor? Yes / No
Have you had a "reaction" to any anesthetic? Yes / No *(explain)* _____

LIST ALL OPERATIONS YOU HAVE HAD, INCLUDING COSMETIC SURGERY?

Operation	Year	Doctor	City

Were there any complications? No / Yes _____
Did you have a normal recovery? No / Yes _____
Were you satisfied with the results? No / Yes _____
Have you had an injury, to the face, nose, neck, or eyes? No / Yes
If so, when? _____ Describe: _____
Have you been advised to have a surgical procedure that has not yet been performed? No / Yes
Is having surgery your idea or someone else's idea? _____
Have you read articles in newspapers, magazines, or books about cosmetic surgery? No / Yes
(*list publications*)_____
Do you understand that the goal of any cosmetic surgery is **improvement** in appearance, not perfection? No / Yes

CHECK BELOW THE REASONS WHY YOU DESIRE TREATMENT:

____ To improve my appearance
____ To improve function
____ To give perfection to my looks
____ To help me look better for my age
____ To give me a psychological uplift
____ To help obtain or keep a job
____ To please or impress others
____ To achieve certain career goals
____ I feel like I look tired
____ To help solve personal problems
____ To eliminate self-consciousness about my appearance
____ Because people tease me or make derogatory remarks
____ To make me look masculine or feminine
____ My looks prevent achievement of certain goals
____ To improve my relations with the opposite sex
____ To cause other people to react better to me
____ Because of a family resemblance I dislike
____ Have an inferiority complex about my appearance
____ My looks prevent achievement of certain goals
____ Other: _____

Are you currently suffering, or have you suffered from any of the following illnesses listed below?

Heart trouble ☐yes ☐no	Lung disease ☐yes ☐no	Stomach/bowel trouble ☐yes ☐no	Jaundice/hepatitis ☐yes ☐no
Joint problems ☐yes ☐no	Diabetes ☐yes ☐no	Seasonal Allergies ☐yes ☐no	Headaches/migraines ☐yes ☐no
Severe stress reaction ☐yes ☐no	Serious accident ☐yes ☐no	High Blood Pressure ☐yes ☐no	Asthma ☐yes ☐no
Hernia or perforation ☐yes ☐no	Kidney/bladder disorder ☐yes ☐no	Back/neck problems ☐yes ☐no	Seizures/blackouts/epilepsy ☐yes ☐no
Depression/anxiety ☐yes ☐no	Hearing/sight problems ☐yes ☐no	Skin problems ☐yes ☐no	Immune disorders ☐yes ☐no
Sleep apnea ☐yes ☐no	Thyroid disorder ☐yes ☐no	Stroke ☐yes ☐no	Bleeding abnormalities ☐yes ☐no
Cancer ☐yes ☐no	Anesthesia Reaction ☐yes ☐no	DVT/Blood Clots ☐yes ☐no	Dry Eyes ☐yes ☐no

If you answered yes to any of the above, please describe below.

_____
_____
_____

Indicate if any member of <u>your family</u> has had trouble with:

			RELATIONSHIP
Diabetes	No	Yes	_____
Heart Trouble	No	Yes	_____
High blood pressure	No	Yes	_____
Excessive scarring	No	Yes	_____
Cancer, including skin cancer	No	Yes	_____
Anesthesia or malignant hyperthermia	No	Yes	_____

Please answer the following questions to the best of your knowledge:

No Yes Do you drink any alcoholic beverages? If so, how many per week? _____

No Yes Do you smoke cigarettes? If so, for how long and how many per week? _____

No Yes Do you use any illegal substances? If so, what? _____

No Yes Do you use steroids? If so, what kind? _____

No Yes Have you ever been tested for HIV?
If YES, what was the result of this test: *(circle one)* positive / negative

No Yes Have you ever had any of the following skin conditions? *(circle all that apply)*
vitiligo/skin pigmentation disorder/shingles/keloid scarring/cold sores/fever blisters

No Yes Are you taking or have you taken **Accutane**? When? _____

No Yes Are you using Retin-A, retinol, or any other vitamin A derivatives?

No Yes Have you used or are you using prescription skin preparations?
Please list_____

No Yes Have you ever seen a Psychologist/Psychiatrist for any of the following? *(circle all that apply)*
Depression/Schizophrenia/Nervous Breakdown/Drug Rehabilitation
Alcohol Rehabilitation/Anxiousness/Other_____

No Yes Do you often feel unhappy or depressed?

No Yes Does criticism always upset you?

No Yes Are you considered a nervous person?

No Yes Are you easily upset or irritated?

No Yes Do you usually sleep well?

No Yes Is your appetite OK?

No Yes Do you hold a grudge when someone angers you?

No Yes Do you have any medical problems that have not been covered?
Explain: _____

Women:

No Yes Have you had a hysterectomy? If so, when? _____

No Yes Are your periods often irregular?

No Yes Have you had GYN problems? If so, explain _____

No Yes Is there any possibility that you are pregnant?

No Yes Have you had a mammogram? If so, when? _____ Results? _____
When was your last menstrual period? _____
Who is your family Doctor? _____
City_____ Phone number _____
When was your last physical examination? _____
May we contact him/her in regard to your medical history? No Yes

Men:

No Yes Have you had prostate problems? If so, explain _____
Who is your family Doctor? _____
City_____ Phone number _____
When was your last physical examination? _____
May we contact him/her in regard to your medical history? No Yes

Who would you like us to contact in the event of an emergency?

NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____

***Signed** _____ **Date**_____

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HIPAA Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We will always continue to conduct accurate assessment of the potential risk to your electronic protected health information within our systems and those of other medical providers we share information with. In the event of any security breach of our electronic systems, you will be notified and the security breach shall be rectified immediately to insure patient information remains protected.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

- If you wish to extend who we may allow to disclose your PHI information to, please provide their name(s):_____.
- If you wish to have the consent to use or disclose your PHI revoked, please provide a time period for such revocation if any, if none, write none: _____.
- If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

  _____ Initial
- You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient Name: _____ Signature_____ Date_____

IMAGING INFORMED CONSENT

In the course of consultations at Buckhead Facial Plastic Surgery, I have been shown or may be shown pictures on an electronic imaging device. I understand that those pictures and alterations of those pictures are solely for the purpose of illustration, discussion, and communication. I understand that the outcome of my treatment is directly related to my individual healing characteristics, and there may be a difference between the electronic images and my final result.

Signed: _____ Date: _____
Witnessed: _____ Date: _____

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Email Consent Form

Patient Name: _____ Patient Date of Birth: _____

Patient E-mail:_____

1. Risk of using E-mail:
Transmitting patient information by E-mail has a number of risks that patients should consider.

a) E-mail can be circulated, forwarded, stored electronically/on paper, and broadcasted to unintended recipients.
b) E-mail senders can easily misaddress an E-mail.
c) Backup copies of E-mail may exist even after the sender or recipient has deleted his or her copy.
d) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
e) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
f) E-mail can be used to introduce viruses into computer systems.

2. Conditions for the use of E-mail:
The provider cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. The patient and provider must consent to the following conditions:

a) E-mail is not appropriate for urgent or emergency situations. The provider cannot guarantee that any particular E-mail will be read or responded to.
b) E-mail must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
c) E-mail communications between patient and provider will be filed in the patient's permanent medical record or departmental file.
d) The patient's messages may also be delegated to another provider or staff member for response. Office staff may also receive and read or respond to patient messages.
e) The provider will not forward patient-identifiable E-mails outside the Buckhead Facial Plastic Surgery system without the patient's prior written consent, except as required by law.
f) The patient should not use E-mail for communication regarding sensitive medical or financial information.
g) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. Instructions:
To communicate by E-mail, the Patient shall:

a) Avoid use of his/her employer's computer.
b) Put the Patient's name in the body of the E-mail.
c) Put the topic (e.g., medical question, labs, surgery, injectables)
d) Inform the Provider of changes in the Patient's E-mail address.
e) Take precautions to preserve the confidentiality of E-mail and any attached documents.
f) Contact the Provider's office via conventional communication methods (phone, fax etc.) if the Patient does not receive a reply within a reasonable period of time.

4. Patient Acknowledgment and Agreement
I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Provider and me. I consent to the conditions and instructions outlined here, as well as any other instructions that the Provider may impose to communicate with me by E-mail. I agree to use only the pre-designated E-mail address specified above. Any questions I may have had were answered.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____