THE MEDSPA AT INNOVATIVE SURGICAL ARTS

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish. There is room to explain your answers more completely on the back of the second page. **Please Type or Print.**

NAME: ______________________________ **DATE OF BIRTH:**__________ **AGE:**______
Last First M

ADDRESS (CITY,ST) ______________________________

OCCUPATION:______________________________ **CELL PHONE:** ______________

EMAIL:______________________________

EMERGENCY CONTACT: ______________________________ **PHONE:**______________

HOW DID YOU HEAR ABOUT OUR OFFICE? ______________________________

PROCEDURES I WOULD LIKE TO DISCUSS WITH THE DOCTOR

____

____

PHARMACY PREFERENCE (LOCATION):______________ **PHARMACY PHONE:**______________

MEDICATIONS

Please list any medications ***including aspirin, vitamins, over-the-counter, or herbal medication***?

Medication Name	***Dose***	***How Often Taken***

THE MEDSPA AT INNOVATIVE SURGICAL ARTS

ALLERGIES

Name	*Type of Reaction*
Do you have environmental Allergies?	☐Yes ☐No Please list:
Do you have food Allergies?	☐Yes ☐No Please list:
Do you have a known allergy to Latex?	☐Yes ☐No.

PAST MEDICAL HISTORY *Have you ever been DIAGNOSED with any of the following problems?*

	Yes	No	Year	Comment
CANCER (please list type):	☐	☐		
Cardiovascular				
Do you have a pacemaker	☐	☐		
High/Elevated Cholesterol	☐	☐		
High Blood Pressure	☐	☐		
Other Heart Problems	☐	☐		
Respiratory				
Asthma	☐	☐		
COPD	☐	☐		
Tuberculosis	☐	☐		

PAST MEDICAL HISTORY *Continued*

	Yes	No	Year	Comment
Gastrointestinal				
Hepatitis	☐	☐		
Reflux	☐	☐		
Stomach ulcers	☐	☐		
Kidney				
Renal Failure	☐	☐		
Mental and Emotional				
Depression (requiring treatment)	☐	☐		
Anxiety (requiring treatment)	☐	☐		
Hematologic/Immunity				
Anemia	☐	☐		
HIV/AIDS	☐	☐		
Hepatitis	☐	☐		
Mononucleosis	☐	☐		
Bleeding after surgery	☐	☐		
Blood transfusion	☐	☐		

THE MEDSPA AT INNOVATIVE SURGICAL ARTS

GYNECOLOGIC HISTORY ***(Women, please complete the following)***

	Yes	No	Comment
Menses/Pregnancies/Births			
Could you be pregnant?	☐	☐	
Date of last menstrual period:	___/___/___		
# of pregnancies:___ # of live births:___			
Current contraceptive use:	__________		
Nursing			
Are you nursing?	☐	☐	
How many months total have you nursed?	#	months	
Hormone History			
Have you ever taken any hormones? (Estrogen, Progesterone, Testosterone, or Birth Control Pills)	☐	☐	
Number of years taking hormones?	#	years	
Breast Health – Have you ever had:			
bloody nipple discharge?	☐	☐	
Non-bloody nipple discharge?	☐	☐	
Injury to breasts?	☐	☐	
Breast infections?	☐	☐	
Pain in breasts?	☐	☐	
Breast biopsy?	☐	☐	
Breast Cancer Risk Profile:			
Do you consider yourself:			
• Caucasian/non-black	☐	☐	
• Hispanic	☐	☐	
• Black	☐	☐	
Date of last mammogram:	___/___/___		
Result:	__________		
Age at first live birth?	__________		
Number of mother/sisters/daughters with Breast cancer:	_#________		GAIL Model Score: 5 year ________ Lifetime: ________ *(High Risk = 5 yr risk >=1.7%)*
Number of previous breast biopsies:	_#________		

	Yes	No	Comment
Vaginal Rejuvenation:			
Do you suffer from urinary leakage?	☐	☐	
Do you suffer with vaginal dryness/irritation?	☐	☐	
Are you concerned with vaginal laxity?	☐	☐	
Do you have discomfort during intercourse?	☐	☐	
Any decrease in libido/sexual function?	☐	☐	

THE MEDSPA AT INNOVATIVE SURGICAL ARTS

Diabetes:

Are you Diabetic? Yes No

If so, what medications do you take? ______________________

____

PAST SURGIAL HISTORY

Have you ever been hospitalized for a medical problem before? ☐Yes ☐No		Please list below:	
Year	**Reason for Admission**	**Date**	**Physician**

ANESTHESIA HISTORY

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐Yes ☐No	If yes, please indicate which type of anesthesia and check reaction(s) below:	
	Reaction	
☐ General Anesthesia	☐ No Problems	☐ Nausea ☐ Vomiting ☐ Slow Awakening ☐ Difficult Intubation ☐ Other
☐ IV Sedation	☐ No Problems	☐ Nausea ☐ Vomiting ☐ Slow Awakening ☐ Other
☐ Epidural/Spinal	☐ No Problems	☐ Nausea ☐ Vomiting ☐ Bleeding ☐ Headache ☐ Other
☐ Regional Block	☐ No Problems	☐ Insufficient ☐ Prolonged ☐ Systemic Reaction ☐ Other
☐ Local	☐ No Problems	☐ Insufficient Block ☐ Heart Palpitations ☐ Systemic Reaction ☐ Other

Additional Anesthesia Questions:	**Yes**	**No**	**Comment**

THE MEDSPA AT INNOVATIVE SURGICAL ARTS

Do you have personal or family history of unexpected death following general anesthesia or exercise?	☐	☐	
A personal or family history of Malignant Hyperthermia?	☐	☐	
A muscle or neuromuscular disorder?	☐	☐	
High temperature following exercise?	☐	☐	
A personal history of muscle spasm?	☐	☐	
Dark or chocolate colored urine?	☐	☐	
Unanticipated fever immediately following anesthesia or serious exercise?	☐	☐	

FAMILY HISTORY ***Please mark all that apply:***

					Maternal		Paternal	
	Mother	**Father**	**Brother**	**Sister**	**Grandmother**	**Grandfather**	**Grandmother**	**Grandfather**
Specific Anesthesia problem	☐	☐	☐	☐	☐	☐	☐	☐
CANCER (please list type) under check mark	☐	☐	☐	☐	☐	☐	☐	☐
Cardiovascular:								
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐	☐	☐	☐	☐
Respiratory:								
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Neurologic:								
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Hematologic								
Bleeding/clotting problem	☐	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

Have you smoked in the past	☐Yes	☐No	Comments (indicate amount per day):
Do you smoke now?	☐Yes	☐No	
ANY nicotine in last 3 months?	☐Yes	☐No	
Do you drink alcohol?	☐Yes	☐No	Comments (indicate amount per week):
Have you ever used any recreational drugs	☐Yes	☐No	Comments (indicate frequency):

THE MEDSPA AT INNOVATIVE SURGICAL ARTS

REVIEW OF SYSTEMS ***Have you RECENTLY had any of the following problems?***

	Yes	No	Comment
General Health Problems:			
Fever	☐	☐	**What is your current Height: __________**
Chills	☐	☐	**Weight: ________**
Night Sweats	☐	☐	
Weight Loss/Gain > 10 lbs/1 month	☐	☐	
Fatigue	☐	☐	
Head/Neck Problems:			
New Headache	☐	☐	
Vision/Eye problems	☐	☐	
Earache, loss of hearing	☐	☐	
Chronic sinus infections	☐	☐	
Cardiovascular Problems:			
Blacking out/Fainting	☐	☐	
Bluish discoloration of lips/fingernails	☐	☐	
Chest pain	☐	☐	
Irregular heartbeat/palpitations	☐	☐	
Swelling of ankles	☐	☐	
Respiratory Problems:			
Frequent non-productive cough	☐	☐	
Frequent productive cough	☐	☐	
Shortness of breath	☐	☐	
Short of breath climbing 1 flight of stairs	☐	☐	
Wheezing	☐	☐	
Gastrointestinal Problems:			
Difficulty swallowing/food sticking in throat	☐	☐	
Abdominal pain	☐	☐	
Constipation	☐	☐	
Diarrhea	☐	☐	
Heartburn	☐	☐	
Nausea	☐	☐	
Vomiting	☐	☐	
Blood in stools	☐	☐	
Black, tar-like stools	☐	☐	
Neurologic Problems:			
Numbness	☐	☐	
Tingling	☐	☐	
Seizures	☐	☐	
Weakness	☐	☐	
Urologic Problems:			
Blood in urine	☐	☐	
Difficulty starting urine stream	☐	☐	
Burning	☐	☐	
Leaking of urine	☐	☐	
Mental and Emotional Problems:			
Depression (requiring treatment)	☐	☐	
Anxiety (requiring treatment)	☐	☐	
Endocrine Problems:			
Temperature fluctuations (feel hot/cold)	☐	☐	
Weight gain or decrease in metabolism	☐	☐	
Diabetes or family history of diabetes	☐	☐	
Thyroid disease	☐	☐	
Fatigue or decrease in energy	☐	☐	
Hematologic Problems:			
Swollen Lymph Nodes	☐	☐	
Bruising easily	☐	☐	
Bleeding into joints	☐	☐	

THE MEDSPA AT INNOVATIVE SURGICAL ARTS

Skin Problems:			
Autoimmune Disorders	☐	☐	
Itching	☐	☐	
Rash	☐	☐	
Burns	☐	☐	

Signature: ______________________________ **Date:**____________________

THE MEDSPA AT INNOVATIVE SURGICAL ARTS
Art.....Defying Gravity

Photo/Video Consent

I, ____________________, give my informed and voluntary consent to Melinda Miller-Thrasher, M.D. and/or his associates to take photographs and/or videos of me pre-operatively, intra-operatively, and post-operatively.

I authorize the use and disclosure of: (Please check all that apply)

- o My name
- o My photographic/video images taken pre-operatively, intraoperatively, and post-operatively
- o My testimonial

I understand that the information will be shown on television, social media, and on the practice website to show the transformation process to the general public, which includes current and prospective patients. All pictures will remain anonymous and any identifying feature will be blurred out as best as possible. However, I also understand that in some rare circumstances the photographs and/or videos may display features that identify me.

I understand entirely that this authorization is completely voluntary. I understand that any disclosure of information pursuant to this consent has the potential of re-disclosure and may no longer be protected by HIPAA privacy regulations and any other applicable federal and/or state confidentiality rules. Dr. Melinda Miller-Thrasher and/or his associates will not be liable should you disclose any identifying factors to a third party, as they may not be required to maintain your privacy.

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects the disclosure moving forward and is not retroactive. This authorization expires 99 years from the date signed.

I understand that the practice cannot condition treatment on whether I sign this authorization.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my information. By signing this consent, I hereby, knowingly and voluntarily authorize Melinda Miller-Thrasher, M.D., to use my photograph(s) and videos in the manner described above.

☐ Yes, I would like a copy of this form. Copy provided _____

Signature ____ Date ________________

Relationship to Patient: ______________________________________