PATIENT HISTORY AND REVIEW OF SYSTEMS

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Physician:_____ **Date:**_____

Patient Name:_____ **Chief Complaint:**_____

History of present illness:

- **Location**_____
(Where is the pain/problem?)
- **Quality**_____
(Example: normal versus abnormal color, activity, etc.)
- **Severity**_____
(How severe is the pain/problem on a scale of 1-5?)
(5 being the most severe)
- **Duration**_____
(How long have you had this pain/problem? or,
When did it start?)
- **Timing**_____
(Does this pain/problem occur at a specific time?)
- **Context**_____
(Where were you at the onset of this pain/problem?)
- **Associated signs/symptoms**_____
(What other associated problems have you been having?)
- **Modifying factors**_____
(What makes the pain/problem worse or better? or. Have you had previous episodes?)

Medical History:

- **Patient medical history:**

			Previous Hospitalization/Surgeries/Serious Injuries	When?
Diabetes	No	Yes	_____	
Hypertension	No	Yes	_____	
Cancer	No	Yes	_____	
Stroke	No	Yes	_____	
Heart Trouble	No	Yes		
Arthritis/gout	No	Yes	Medications:	
Convulsions	No	Yes	_____	
Bleeding tendency	No	Yes	_____	
Acute Infections	No	Yes	_____	
Venereal disease	No	Yes	_____	
Hereditary disease	No	Yes	_____	

- **Patient social history:**

Marital status: Single____ Married____ Separated____ Divorced____ Widowed____
Use of alcohol: Never____ Rarely____ Moderate____ Daily____
Use of tobacco Never____ Previously, but quit ____ Current packs/ day_____
Use of drugs Never____ Type/Frequency:_____
Excessive exposure at home or work to: Fumes:___ Dust:____ Solvents:____ Air-borne Particles____ Noise_____

- **Family medical history:**

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Reviewed by:_____ Date:_____

Review of Systems: Please indicate any personal history below:

- **CONSTITUTIONAL SYMPTOMS**
  - Good general health lately..... No Yes
  - Recent weight change..... No Yes
  - Fever..... No Yes
  - Fatigue..... No Yes
  - Headaches..... No Yes

- **EYES**
  - Eye disease or injury..... No Yes
  - Wear glasses/contact lenses..... No Yes
  - Blurred or double vision..... No Yes
  - Glaucoma..... No Yes

- **EAR/NOSE /MOUTH/THROAT**
  - Hearing loss or ringing..... No Yes
  - Earaches or drainage..... No Yes
  - Chronic sinus problem or rhinitis..... No Yes
  - Nose bleeds..... No Yes
  - Mouth sores..... No Yes
  - Bleeding gums..... No Yes
  - Bad breath or bad taste..... No Yes
  - Sore throat or voice change..... No Yes
  - Swollen glands in neck..... No Yes

- **CARDIOVASCULAR**
  - Heart trouble..... No Yes
  - Chest pain or angina pectoris..... No Yes
  - Palpation..... No Yes
  - Shortness of breath with walking or lying flat..... No Yes
  - Swelling of feet, ankles, or hands..... No Yes

- **RESPIRATORY**
  - Chronic or frequent coughs..... No Yes
  - Spitting up blood..... No Yes
  - Shortness of breath..... No Yes
  - Asthma or Wheezing..... No Yes

- **GASTROINTESTINAL**
  - Loss of appetite..... No Yes
  - Change in bowel movements..... No Yes
  - Nausea or vomiting..... No Yes
  - Frequent diarrhea..... No Yes
  - Painful bowel movement or constipation.. No Yes
  - Rectal bleeding or bloods in stool..... No Yes
  - Abdominal pain..... No Yes
  - Peptic ulcer(stomach or duodenal)..... No Yes

- **GENITOURINARY**
  - Frequent urination..... No Yes
  - Burning or painful urination..... No Yes
  - Blood in urine..... No Yes
  - Change in force of strain when urinating.. No Yes
  - Incontinence or dribbling..... No Yes
  - Kidney stones..... No Yes
  - Sexual difficulty..... No Yes
  - Male- testicle pain..... No Yes
  - Female- pain with periods..... No Yes
  - Female- irregular periods..... No Yes
  - Female-vaginal discharge..... No Yes
  - Female- # of pregnancies..... _____
  - Female- # of miscarriages..... _____
  - Female- date of last pap smear..... _____

- **MUSCULOSKELETAL**
  - Joint pain..... No Yes
  - Joint stiffness or swelling..... No Yes
  - Weakness of muscles or joints... No Yes
  - Muscle Pain or cramps..... No Yes
  - Back Pain No Yes
  - Cold extremities No Yes
  - Difficulty in walking..... No Yes

- **INTEGUMENTARY(skin, breast)**
  - Rash or itching..... No Yes
  - Change in skin color..... No Yes
  - Change in hair or nails..... No Yes
  - Varicose Veins..... No Yes
  - Breast Pain..... No Yes
  - Breast Lump..... No Yes
  - Breast Discharge..... No Yes

- **NEUROLOGICAL**
  - Frequent or recurring headaches... No Yes
  - Light headed or dizzy..... No Yes
  - Convulsions or seizures..... No Yes
  - Numbness or tingling sensations... No Yes
  - Tremors..... No Yes
  - Paralysis..... No Yes
  - Stroke..... No Yes
  - Head injury..... No Yes

- **PSYCHIATRIC**
  - Memory loss or confusion..... No Yes
  - Nervousness..... No Yes
  - Depression..... No Yes
  - Insomnia..... No Yes

- **ENDOCRINE**
  - Glandular or hormone problem..... No Yes
  - Thyroid disease..... No Yes
  - Diabetes (insulin or non insulin)..... No Yes
    -circle one
  - Excessive thirst or urination..... No Yes
  - Heat or cold tolerance..... No Yes
  - Skin becoming dryer..... No Yes
  - Change in hat or glove size..... No Yes

- **HEMATOLOGIC/LYMPHATIC**
  - Slow to heal after cuts..... No Yes
  - Bleeding or bruising tendency..... No Yes
  - Anemia..... No Yes
  - Phlebitis..... No Yes
  - Past transfusion..... No Yes
  - Enlarged glands..... No Yes

- **ALLERGIC/IMMUNOLOGIC**
  - History of skin reaction or other adverse reaction to:
  - Penicillin or other antibiotics..... No Yes
  - Morphine or other antibiotics..... No Yes
  - Novocain or other anesthetics..... No Yes
  - Aspirin or other pain remedies..... No Yes
  - Tetanus antitoxin or other serums... No Yes
  - Iodine, methiolate or other antiseptic No Yes
  - Other drugs/medications:_____
  - Known food allergies:_____
  - Environmental allergies:_____

Review by:_____ Date:_____

The Aesthetic Center for Plastic Surgery

ACPS
THE AESTHETIC CENTER FOR PLASTIC SURGERY

Date: _____

(For Office Use Only) ACCT #:

Christopher K. Patronella, M.D., FACS, FICS ~ Henry A. Mentz, III, M.D., FACS, FICS ~ German Newall, M.D., FACS, FICS
Paul F. Fortes, M.D., FACS, FICS ~ James F. Boynton, M.D., FACS

SECTION I: PATIENT INFORMATION (please print)

Patient's Last Name	First Name	Middle	[ ] Single [ ] Married	Date of Birth
			[ ] Male [ ] Female	Age
Address	City, State	Zip	Name of Spouse or Responsible Party	
May we mail info or contact you at home? YES ☐ NO ☐			Cellular Phone # ( ) -	Home Phone # ( ) -
E-mail (we do not share your information with anyone)				
Are you here today as a result of an accident? YES ☐ NO ☐			Employer	WK # ( ) -
Social Security #	Driver's License #	State	May we contact you at work? YES ☐ NO ☐	

SECTION II: MEDICAL INFORMATION

Reason for visit with Doctor?

What areas concern you? (check all that apply)

FACE:	BODY:	BREASTS:	SKIN:
☐ Eyes	☐ Chest	☐ Too small	☐ Texture
☐ Eye brows	☐ Abdomen	☐ Too large	☐ Age spots
☐ Nose	☐ Flanks	☐ Sagging	☐ Large pores
☐ Jowls	☐ Back	☐ Uneven	☐ Red splotches
☐ Cheeks	☐ Hips	☐ Nipple abnormality	☐ Acne
☐ Chin	☐ Arms		☐ Discoloration
☐ Neck	☐ Inner thigh	Other:	☐ Scarring
☐ Ears	☐ Outer thigh	☐ Spider veins	☐ Other
☐ Wrinkles	☐ Calves	☐ Excessive hair	
☐ Skin laxity	☐ Ankles	☐ _____	

List any current illnesses/conditions

List all medications currently taking

List any known ALLERGIES	Name of primary physician	Phone Number

SECTION III: RESPONSIBLE PARTY

If you are under the age of 18 you must have a parent or legal guardian fill out this section.

Responsible Party's Last Name	First Name	Relation to Patient	
Address	City, State	Zip	Cellular Phone # ( ) - / Home Phone # ( ) -
Date of Birth	SS#	Driver's License #	State

PLEASE COMPLETE AND SIGN THE BACK OF THIS FORM>>>>

SECTION IV: PAYMENT / INSURANCE INFORMATION

Method of Payment

☐ Cash ☐ Credit Card ☐ Workers Comp ☐ Other: _____
☐ Check ☐ Insurance ☐ Medicare/Medicaid

Insurance Company Name	Insured ID #s	Name of Insured	Relationship to Patient
			☐ Self ☐ Spouse ☐ Parent ☐ Other
Secondary Insurance	Insured ID #s	Name of Insured	Relationship to Patient
			☐ Self ☐ Spouse ☐ Parent ☐ Other

SECTION V: TREATMENT PRIVACY

Your privacy is very important to us. Please list individuals below with whom we may discuss your treatment. We will not discuss any aspects of your care with anyone else without your permission. Should this information change, please contact us in writing with your requests.

Name:	Relationship:
Name:	Relationship:

When you contacted ACPS for the first time, did you:

_____ Call us?
_____ Complete a contact form on our web site?
_____ Other:

Where have you heard about ACPS and our surgeons? Check all that apply.

REFERRAL FROM:

_____ Friend/Family member. May we ask who referred you?_____
_____ Physician
_____ Seminar/Leisure Learning

TELEVISION/RADIO/VIDEO:

_____ Click 2 Houston
_____ TV commercial
_____ TV interview with one of our surgeons
_____ Radio commercial
_____ Radio interview with one of our surgeons
_____ LifeTime Fitness Video

INTERNET:

Did you visit our web site for the first time because:

_____ You were searching the internet for information about plastic surgery.
_____ You saw our web site listed in a print advertisement in a magazine.
_____ You heard our web site mentioned in a television commercial.
_____ You linked to our web site because you were visiting another web site. Which web site did you visit before you linked to ours? →

PRINT ADVERTISING: Have you seen us here?

_____ Health and Fitness Magazine
_____ H-Texas Magazine
_____ New Beauty Magazine
_____ Newsweek Magazine
_____ Modern Luxury Magazine
_____ Fortune 500 Magazine
_____ Houston LifeStyle Magazine
_____ Houston Symphony Magazine
_____ LifeTime Fitness Poster

I understand that I am financially responsible for ALL CHARGES, whether or not covered in whole or in part by **insurance**. If these services are covered by insurance, I authorize ACPS to release my medical records for insurance purposes and to file with my insurance carrier on my behalf. I assign any payments directly to ACPS for the covered procedures. If insurance verification for the procedure has been obtained, the deductible and co-insurance are due five (5) business days prior to the surgery date. ACPS cannot guarantee what amount insurance will cover and I am responsible for the balance. Co-insurance and any deductible owed are estimates only and additional payments may be due after the surgery is performed. If a refund is due, it will be made only for procedures specifically covered by insurance and after ACPS receives all payments due from the insurance carrier. I understand that if surgery is performed at a facility other than ACPS, I may incur other charges not related to my ACPS bill. Related co-insurance payments due to entities other than ACPS are my responsibility. **Cosmetic procedures** are not covered by insurance, and I understand that I am financially responsible for all charges related to my cosmetic procedure(s). Payment in full is due five (5) business days prior to surgery or surgery may be postponed. A deposit of 10% of the quoted surgery fee is required to schedule surgery. In the event I cancel surgery less than ten (10) business days before the scheduled surgery date, the 10% deposit will be forfeited. If the procedure is rescheduled and performed within twelve (12) months of the original surgery date, the 10% will apply to the rescheduled surgery. If someone other than me has elected to pay for my surgery via check or credit card prior to the surgery, I am and remain financially responsible for all charges should this individual dispute these charges after the surgery is performed.

Signature of Patient or Legal Guardian: _____ Date:_____