

# MEDICAL AND SURGICAL HISTORY

MICHAEL C. EDWARDS, MD, FACS

EDWARDS PLASTIC SURGERY

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

**What brings you to see Dr. Edwards today?** (Please check the box(s) that apply to you)

**Breast Surgery:**  Breast Enlargement  Breast Lift  Breast Reduction  Asymmetry Correction  Implant Revision

**Body Contouring:**  Tummy Tuck  Thigh Lift  Arm Lift  \_\_\_\_\_

**Liposuction:**  Abdomen  Flanks  Bra Rolls  Thighs (Inner/Outer)  Hip Rolls  Arms  \_\_\_\_\_

**Other:**  \_\_\_\_\_

**What are your goals from this visit and from surgery?** \_\_\_\_\_

\_\_\_\_\_

**Please explain how you have managed this concern?** \_\_\_\_\_

\_\_\_\_\_

**CHIEF COMPLAINT** (Dr. Edwards will fill this in): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Breast CA Risk Factors (for women):** 1. How old were you when you started periods? \_\_\_\_\_ 2. How old were you with your 1<sup>st</sup> pregnancy; \_\_\_\_\_ 3. Is there a **family history** of breast cancer?  N  Y (please explain)

4. Are you still having periods?  Y  N What was the date of your last period: \_\_\_\_\_

**How many pregnancies have you had?** \_\_\_ **How many deliveries have you had ?** \_\_\_ [C-section \_\_\_ Vaginal \_\_\_]

5. Date of your last **mammogram**: \_\_\_\_\_

**PAST MEDICAL HISTORY** (please fill out completely)

Who is your **Primary Care Doctor**? \_\_\_\_\_

Do you see any **specialists**? \_\_\_\_\_

**Do you smoke?**  Y  N If yes, how much do you smoke and for how long; \_\_\_\_\_

**MEDICATIONS:** Please list all medications that you take. (This should include **any and all medications** that you take including those you get from a physician, over the internet, over the counter, from another healthcare provider or from **ANY** health food stores. Please list the medication, dose, & how often you take it.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any **allergies** to medications or **latex**? : Please list them & the reactions that you had.  NKDA

\_\_\_\_\_

\_\_\_\_\_

How much alcohol do you drink per week? \_\_\_\_\_ Caffeine or Soda? \_\_\_\_\_

**SOCIAL HISTORY:** What kind of work do you do? \_\_\_\_\_

**CHILDHOOD ILLNESSES:** Did you have any serious illnesses, surgeries or hospitalizations as a child?  Y  N

(Please describe) \_\_\_\_\_

**FAMILY HISTORY:** Is there any history of any of the following problems in blood relative family members?

Diabetes  Arthritis  Asthma or lung disease  *Anesthesia complications*  Breast Cancer  Cardiac  Cancer

High blood pressure  *Bleeding or Clotting tendencies*  Other: \_\_\_\_\_

\_\_\_\_\_

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**REVIEW OF SYSTEMS:** (Check any of these conditions if you **currently** have them)

**GENERAL:**  Chills  Depression  Dizziness  Fainting  Fever  Forgetfulness  Headache/ Migraines  Sweats

Loss of sleep  Loss of weight  Weight gain  Nervousness  Anxiety  Numbness \_\_\_\_\_

**MUSCULOSKELETAL:** Pain or weakness of the;  Neck  Back  Arms  Hands  Hips  Legs  Feet

**GENITOURINARY:**  Blood in urine  Frequent urination  Bladder Infections  Lack of bladder control  Painful urination  Kidney Stones \_\_\_\_\_

**GASTROINTESTINAL:**  Poor appetite  Bloating  Bowel changes  Constipation  Diarrhea  \_\_\_\_\_

Nausea  Vomiting  Rectal bleeding  Gastric Reflux  Ulcers \_\_\_\_\_

**CARDIOVASCULAR:**  Chest pain  High blood pressure  Low blood pressure  Irregular heart beat  Poor circulation

Rapid heart beat  Heart attack  Varicose veins \_\_\_\_\_

**ENDOCRINE:**  Diabetes  Thyroid disorders  \_\_\_\_\_

**EYE, EAR, NOSE, THROAT:**  Blurred vision  Vision flashes  Double vision  Ringing in the ears  Loss of hearing

Nose bleeds  Sinus problems  Difficulty swallowing  Hoarseness  Bleeding gums \_\_\_\_\_

**RESPIRATORY:**  Persistent or chronic cough  Shortness of breath at rest or with exercise  Do you ever cough up

blood?  Wheezing  Do you lose your breath with minor exertion?  Have had an abnormal chest x-ray

**PSYCHOSOCIAL STRESS:**  Recent death in the family  Current or previous legal action  Recent Marriage / Divorce /

Birth  Change in job or residence \_\_\_\_\_

**SKIN:**  Bruise easily  Hives  Itching  Change in moles  Rash  Skin cancer \_\_\_\_\_

**WOMEN ONLY:**  Breast lump(s)  Nipple discharge  Abnormal mammogram \_\_\_\_\_

**Is it possible that you are pregnant?**  Y  N \_\_\_\_\_

**Have you ever been told you need antibiotics for surgery or dental work because of a heart murmur?**  Y  N

**ADULT ILLNESS: Do you have or have you ever had any of the following conditions/diagnoses?**

AIDS/ HIV positive  Alcoholism  Anemia  Anorexia  Arthritis  Asthma  Bleeding  Bulimia  Bronchitis

Cancer  Diabetes  Emphysema  Epilepsy  Glaucoma  Goiter  Gout  Hepatitis  Heart disease  Hernia

Herpes  High Blood Pressure  High cholesterol  Migraine Headaches  Kidney disease(s)  Liver disease  Mono

Multiple sclerosis  Pacemaker  Pneumonia  Prostate problem  Have you ever been treated for anxiety or

depression?  Have you ever been hospitalized for psychiatric reasons?  Rheumatic fever  Scarlet fever  Stroke

Thyroid problems  Ulcers  Deep Vein Thrombosis (DVT)  Pulmonary Embolus \_\_\_\_\_

**Have you had any vaccine series**  Y  N:  Hepatitis A  Hepatitis B **Have you had titers drawn?**  Y  N

**PAST SURGICAL HISTORY:** (please list all surgeries that you have had)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Michael C. Edwards, MD, FACS

**NEW PATIENT REGISTRATION INFORMATION  
EDWARDS PLASTIC SURGERY**

Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
Last Name First Name Middle Initial

How do you prefer to be addressed:  First name  Mr.  Mrs.  Ms.  Miss  Doctor  Other: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex  M  F Marital Status:  M  S  D  W

Social Security Number: \_\_\_\_\_ E mail address: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_

**EMPLOYMENT INFORMATION**

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer address: \_\_\_\_\_ Work phone: \_\_\_\_\_

**RESPONSIBLE PARTY** (if patient is a minor): \_\_\_\_\_

Relationship to patient:  Parent  Spouse  Guardian  Other Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer phone: \_\_\_\_\_

Employer address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**INSURANCE INFORMATION** Do you have medical insurance?  Y  N

Primary insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Group name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Subscriber's date of birth: \_\_\_\_\_

How did you hear about us?  Friend \_\_\_\_\_  Magazine: \_\_\_\_\_

Internet \_\_\_\_\_  Paper  Radio

In case of emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

**ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY**

1. I/We hereby consent to examination and/or authorize treatment by Dr. Michael C. Edwards or members of his staff.
2. I authorize the release of any information in the course of my evaluation or treatment to my physicians
3. Each patient, not his/her insurance company, is responsible for payment of all charges to your account at the time services are rendered unless special arrangements are agreed to in advance
4. I authorize insurance benefits be paid directly to Michael C. Edwards, MD. I also authorize Dr. Edwards and his staff to release any information required in the course of my evaluation or treatment to the insurance company.
5. Payments on accounts billed are expected within 30 days.
6. Delinquent accounts will be charged 2% interest per month. I agree to pay any and all collection costs and reasonable attorney's fees if any delinquent balance is placed with a collection agency or attorney for collection or suit.
7. I/We agree to pay all legal fees (court costs, attorney fees, filing fees, commissions) that may be assessed by any agency retained to pursue this matter. I/We agree to pay interest at 1.5%/ month or 18%/year)

**Please read and sign below**

RESPONSIBLE PARTY: \_\_\_\_\_ Date: \_\_\_\_\_

**New Patient Consent to the Use and Disclosure of Health Information  
for Treatment, Payment, or Healthcare Operations**

I, \_\_\_\_\_, understand that as part of my healthcare, **Michael C. Edwards, MD, FACS Plastic Surgery** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Michael C. Edwards, MD, FACS Plastic Surgery is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Michael C. Edwards, MD, FACS Plastic Surgery reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Michael C. Edwards, MD, FACS Plastic Surgery change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

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I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY**

[ ] Consent received by \_\_\_\_\_ on \_\_\_\_\_.  
[ ] Consent refused by patient, and treatment refused as permitted.  
[ ] Consent added to the patient's medical record on \_\_\_\_\_.

**AUTHORIZATION FOR EXAMINATION  
Edwards Plastic Surgery**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_

I, \_\_\_\_\_, represent to Dr. Edwards and his staff that I am at least 18 (eighteen) years of age, an emancipated minor or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by Dr. Michael C. Edwards and such assistants or staff as may be assigned by him.

I authorize the release or receipt of any of my medical information as necessary for my care and treatment. I authorize payments of medical benefits directly to Dr. Michael C. Edwards for services provided to me. A copy of this authorization shall be considered as valid as the original. In the event of any litigation arising in the course of my treatment, I agree to submit the case to arbitration. I understand that photography is a necessary part of planning and evaluating the outcome of cosmetic or reconstructive surgery. I authorize taking of photographs by or at the direction of Dr. Michael C. Edwards. These photographs will be used for documentation purposes and additional consent will be required for any other use (please refer to the photography consent).

**CONSULTATION FEE**

I understand that there is a \$50.00 consultation fee for the initial visit. This fee is due at the time of my appointment being scheduled. If a surgical procedure is scheduled within a 90 day period of my date of consultation, this fee will be subtracted from the cost of the procedure.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

RELATIONSHIP: (circle one) PATIENT      SPOUSE      PARENT      GUARDIAN

Michael C. Edwards, MD, FACS  
Edwards Plastic Surgery  
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Las Vegas, Nevada 89144  
(702) 248-8989; Fax (702) 243-7923  
[www.medwardsmd.com](http://www.medwardsmd.com)

**PATIENT CONSENT AND RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION**

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to an individual's office instead of the individual's home.

I, \_\_\_\_\_ wish to be contacted in the following manner: (please check all that apply)

- Home Telephone**
  - OK to leave message with **detailed information on home answering machine**
  - Leave message with **call back number only**
  - OK to leave message **with spouse/significant other at home number**
- Work Telephone**
  - OK to leave message with **detailed information**
  - Leave message with **call back number only**
- Written Communication**
  - OK to mail to **my home address**
  - OK to mail to my **work/office address**
- Electronic Communication**
  - OK to communicate with me by email (this may include newsletters)
  - OK to fax to home/office fax number
  - E mail address: \_\_\_\_\_

It is alright with me to communicate information about me (appt. reminders, updates, test results, etc.) to the following individuals;

\_\_\_\_\_

\_\_\_\_\_

Name	Relationship	Number
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The privacy rule generally requires healthcare providers to take reasonable steps to limit the use of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual. Healthcare entities must keep a record of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record. Note: Uses and disclosures for TPO (Treatment, Payment, or Operations) may be permitted without prior consent for an emergency.

Patient Signature	Date
Patient Name	Date of Birth

**RECORD OF PHI DISCLOSURES**  
 \*\*\*\*\*THIS IS FOR OFFICE USE ONLY\*\*\*\*\*

Date	Disclosed to whom (address or fax)	Description of purpose of disclosure	By whom disclosed