

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 1st 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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Name: _____ Date: _____ Age: _____ Birth date: _____

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 Gastric Reflux

Nausea Vomiting Rectal bleeding Ulcers _____

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

Rapid heartbeat Heart attack Varicose veins Deep Vein Thrombosis (DVT) or Pulmonary Embolus (PE)

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

**AUTHORIZATION FOR EXAMINATION
Edwards Plastic Surgery**

Name: _____ Birthdate: _____

Address: _____

City/State/Zip Code: _____

Home Phone: _____ Cell Phone: _____

Referred By: _____

I, _____, represent to **Michael C. Edwards, MD, FACS/Edwards Plastic Surgery** 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 Michael C. Edwards, MD, FACS/Edwards Plastic Surgery 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 Michael C. Edwards, MD, FACS/Edwards Plastic Surgery 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 Michael C. Edwards, MD, FACS/Edwards Plastic Surgery. These photographs will be used for documentation purposes and additional consent will be required for any other use.

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

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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

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

**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/Edwards 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 offered 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/Edwards 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/Edwards 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/Edwards 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:

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 _____.