

**SKIN CARE
MEDICAL AND SURGICAL HISTORY
EDWARDS PLASTIC SURGERY**

Name: _____ Date: _____ Age: _____ Birth date: _____

What brings you to be seen at Dr. Edwards' office today?: _____

What are your goals from this visit? _____

Have you ever had an unfavorable result from a skin care treatment? (please explain) Y N _____

Which of the following best describes your skin type? (please circle one)

- | | | | |
|-----|------------------------------|----|----------------------------------|
| I | Always burns, never tans | IV | Rarely burns, always tans |
| II | Always burns, sometimes tans | V | Brown, moderately pigmented skin |
| III | Sometimes burns, always tans | VI | Black skin |

Have you had any skin care treatments in the past (lasers, peels, Microdermabrasion, fillers, etc.) ? Y N

What products are you currently using in your skin care regimen? _____

SKIN HISTORY:

- Do you have a history of **livedo reticularis**, an autoimmune disease, in which the blood vessels are constricted, or narrowed resulting in mottled discoloration on large areas of the legs or arms? Y N
 - Do you have a history of **erythema ab igne** (skin reaction caused by chronic exposure to infrared radiation in the form of heat), leaving a persistent skin rash produced by exposure to moderately intense heat or infrared irradiation? Y N
 - Do you have **ANY** skin conditions which you see a Dermatologist or skin care specialist for? Y N
-
- Have you ever had laser hair removal? Y N
 - Have you used any of the following hair removal methods in the past 6 weeks? Y N
 Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories
 - Do you form thick or raised scars from cuts or burns? Y N
 - Have you recently used any self-tanning lotions or treatments? Y N
 - Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? Y N Please describe: _____

PAST MEDICAL HISTORY (please fill out completely)

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;

Accutane (when did you last take it? _____) Birth Control Pills Hormones Retin A

Steroids (when did you take them last?) _____

Do you have any **allergies** to medications, cosmetics, lidocaine, aspirin, hydrocortisone, food or **latex**? : NKDA

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

SOCIAL HISTORY: What kind of work do you do? _____

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

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 tendencies* Other: _____

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

GENERAL: Chills Depression Dizziness Fainting Fever Forgetfulness Headache Sweats Loss of sleep Loss of weight Weight gain Nervousness Anxiety Numbness _____

SKIN: Bruise easily Hives Itching Change in moles Rash Sores that won't heal

ENDOCRINE: Diabetes Thyroid Imbalance Hormone Imbalance _____

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

GENITOURINARY: Blood in urine Frequent urination Lack of bladder control Painful urination Kidney Stones _____

GASTROINTESTINAL: Poor appetite Bloating Bowel changes Constipation Diarrhea Indigestion
 Nausea Vomiting Rectal bleeding Gastric Reflux Ulcers _____

CARDIAC: Chest pain High blood pressure Irregular heart beat Low blood pressure Rapid heart beat

EYE, EAR, NOSE, THROAT: Bleeding gums Blurred vision Difficulty swallowing Hoarseness Double vision
 Loss of hearing Nose bleeds Ringing in the ears Sinus problems Vision flashes

RESPIRATORY: Persistent or chronic cough Shortness of breath at rest or with exercise Wheezing

PSYCHOSOCIAL STRESS: Recent death in the family Legal action Recent Marriage Divorce Birth

Is it possible that you are pregnant? Y N **Are you breast-feeding?** Y N **When did you stop?** _____

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

- Alcoholism Anemia Anorexia Arthritis Asthma Bleeding Bronchitis Cancer Diabetes
 Glaucoma Goiter Hepatitis Heart disease Herpes High Blood Pressure High cholesterol Migraine
Headaches Pneumonia Prostate problem Have you ever been treated for anxiety or depression? Rheumatic
fever Scarlet fever Stroke Thyroid problems Ulcers Other: _____

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

PAST SURGICAL HISTORY: (please list surgeries that you have had (when, where & why)

STATEMENT OF PHYSICIAN EVALUATION AND CONSENT (To be completed by Dr. Edwards)

I have seen and evaluated this patient and found that he/she has Signs of facial aging Hyper/Hypopigmentation
 Body hair that would benefit from hair removal Actinic damage Other: _____

I have discussed the condition(s) with them to include options for treatment to include no treatment, alternatives and a brief overview of the potential risks associated. They will be referred to a skin care specialist in my office for evaluation and a treatment plan will be developed. I will follow this patient as they undergo treatment. The patient has been given every opportunity to ask any and all questions about this plan and possible treatment. This opportunity to ask questions is open-ended through out their care in my office. By my signature on subsequent patient care progress notes, I concur with the continued care and treatment plan.

Michael C. Edwards, MD, FACS

Date

Skin Care Medication Checklist

Please review this list of medications and check any that you are taking or if you have taken in the last year

ANTI-CANCER DRUGS

- Dacarbazine (DTIC-Dome)
- Fluorouracil
- Flutamide (Eulexin)
- Methotrexate (Folex and others)
- Vinblastine (Velban and others)

ANTI-DEPRESSANTS

- Amitriptyline (Elavil & others)
- Amoxapine (Asedin & others)
- Clomipramine (Anafranil)
- Desipramine (Norpramine & others)
- Dexopin
- Imipramine (Torfanil and others)
- Maprotiline (Ludiomil and others)
- Nortriptyline (Aventyl HCl/Pamelor)
- Phenelzine (Nardil)
- Protryptiline (Vivactil)
- Trazodone (Desyrel and others)

ANTI HISTAMINES

- Cyproheptadine (Periactin)
- Diphenhydramine (Benadryl)

ANTI HYPERTENSIVES

- Captopril (Capoten)
- Diltiazem (Cardiazem and others)
- Methyldopa (Aldomet and others)
- Minoxidil (Loniten and others)
- Nifedipine (Procardia and others)

ANTI-PARASITIC DRUGS

- Chloroquine (Aralen and others)
- Quinine (many manufacturers)
- Thiobendazole (Minetezol)

ANTIMICROBIALS/ANTIBIOTICS

- Ciprofloxacin (Cipro)
- Clotazimine (Lamprene)
- Dapsone (generic)

- Demeclocycline (Vibramycin)
- Doxycycline (Vibramycin)
- Enoxacin (Penetrex)
- Flucytosine (Ancobon)
- Griseofulvin (Fluvin-U/F)
- Lomefloxacin (Maxaquin)
- Minocycline (Minocin and others)
- Naladixic Acid (NeGram and others)
- Norfloxacin (Noroxin)
- Ofloxacin (Floxin)
- Oxytetracycline (Terramycin)
- Pyrazinamide (generic)
- Sulfonamides
- Tetracycline (Achromycin)
- Trimethoprim (Proloprim)

ANTIPSYCHOTIC MEDICATIONS

- Chlorpromazine (Thorazine)
- Fluphenazine (Prolixin)
- Haloperidol (Haldol)
- Perphenazine (Trilafon)
- Prochlorperazine (Compazine)
- Thioridazine (Mellaril)
- Thiothixene (Navane)
- Trifluoperazine (Stelazine)

DIURETICS

- Acetazolamide (Diamox)
- Amiloride (Midamor)
- Chlorothiazide (Diuril)
- Furosemide (Lasix)
- Hydrochlorothiazide (HydoDiuril)

I have disclosed all medications that I am now taking or have taken in the past year. I understand that this is important to ensure safe delivery of my skin/health care.

Patient Name

Date

AUTHORIZATION FOR EXAMINATION

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 no consultation fee for skin care visits. There is a consultation fee for consultation for plastic surgery consultations.

SIGNATURE: _____ DATE: _____

RELATIONSHIP: (circle one) PATIENT SPOUSE PARENT GUARDIAN

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

I, _____, understand that as part of my health care, **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:

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 _____.

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 PHOTOGRAPHIC AUTHORIZATION CONSENT

I consent to the taking of photographs or videotapes of me or parts of my body, by Dr. Michael C. Edwards or his designee. I further consent to the release by Dr. Edwards to the American Society for Aesthetic Plastic Surgery, Inc. (ASAPS) or the American Society of Plastic Surgeons, Inc. (ASPS) of such photographs, videotapes or case histories. I understand that such photographs, videotapes or case histories may be published by Dr. Edwards and/or ASAPS-ASPS and/or any party acting under their license and authority in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods. **Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.** I understand that **I have the right to revoke this authorization in writing at any time**, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below. I understand **that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Edwards.**

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because ASAPS-ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be redisclosed by ASAPS-ASPS. I release and discharge Dr. Edwards, ASAPS-ASPS, and all parties acting under their license and authority from all rights that I may have in the photographs, videotapes or case histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium.

I recognize that prospective patients, such as me, will ask to look at before and after photographs in the process of choosing a surgeon and evaluating specific procedures. *I authorize* the anonymous use of my photographs for this purpose by Dr. Edwards.

Yes No

I authorize the anonymous use of my photographs by Dr. Edwards in seminars, health fairs and conferences for interested and/or prospective patients. Yes No

I authorize the anonymous use of my photographs in articles written by Dr. Michael C. Edwards for publication in medical journals so long as I am notified in writing of such use prior to publication. Yes No

I authorize the anonymous use of my photographs in articles written by Dr. Edwards for publication on Dr. Edwards web site or in magazines and newspapers so long as I am notified in writing of such use prior to publication. Yes No

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

Patient

Date

WITNESS: _____

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Patient/Guardian

Date

Michael C. Edwards, MD, FACS Plastic Surgery
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