Michael A. Derlin, M.D.
COSMETIC SURGERY

# Health History Questionnaire

Date _____

Patient Name _____

E-mail _____

Date Of Birth _____ Age _____ Height _____ Weight _____

Family Physician _____ Phone _____ City/State _____

When was your last physical examination? _____

Have you ever had a Chest X-ray? Yes No When? _____ EKG? Yes No When _____

**What procedure are you interested in having?** _____

**Do you have any allergies to medications, iodine or tape? Yes No**

If yes, please list _____

_____

**Are you allergic to Latex? Yes No**

**Have you ever had an adverse reaction to any skin related procedures or cosmetics? Yes No**

**Are you currently taking any medications? Yes No**

If yes, please list _____

_____

**Do You have a Medical Marijuana Card? Yes No**

**Do you take any Herbal or nutritional supplements? Yes No**

If yes, please list _____

**Are you currently taking aspirin, ibuprofen, birth control pills, weight loss, ADD medication? Yes No**

If yes, please list _____

**HAVE YOU BEEN DIAGNOSED WITH OR CURRENTLY HAVING PROBLEMS WITH ANY OF THE FOLLOWING:**

| | | | | | |
|---|---|---|---|---|---|
| Allergies/Seasonal/Nasal | Yes | No | Stroke/TIA | Yes | No |
| Dry Eyes/Blurred Vision/Glaucoma | Yes | No | Severe Headaches | Yes | No |
| Coronary Artery disease | Yes | No | Dizzy/Fainting Spells | Yes | No |
| Heart Attack/Irregular heart beat | Yes | No | Seizures/Convulsions | Yes | No |
| Pacemaker | Yes | No | Paralysis/Numbness/Muscle weakness | Yes | No |
| Heart Murmur/Valve Problems | Yes | No | Abnormal Circulation | Yes | No |
| Mitral Valve Prolapse | Yes | No | Clotting Problems/ Bruising/Bleeding | Yes | No |
| Gall Bladder Disease | Yes | No | Anemia | Yes | No |
| Stomach Ulcers/Reflux | Yes | No | Thyroid Disease | Yes | No |
| Lung Disease/COPD/Emphysema | Yes | No | Arthritis/Fibromyalgia | Yes | No |
| Shortness Of Breath | Yes | No | Autoimmune Disease(Lupus, MS) | Yes | No |
| Asthma | Yes | No | AIDS or Positive HIV Test | Yes | No |
| Sleep Apnea | Yes | No | Cancer | Yes | No |
| Coughing/Spitting up Blood | Yes | No | Sexually Transmitted Disease | Yes | No |
| Tuberculosis | Yes | No | Cold Sores or Fever Blisters | Yes | No |
| Blood Clot in Lungs or Legs | Yes | No | Skin Irritations (Eczema, Psoriasis) | Yes | No |
| High/Low Blood Pressure | Yes | No | Abnormal Scarring | Yes | No |
| Diabetes | Yes | No | MRSA Infection/Staph Infection | Yes | No |
| Kidney/Bladder Disease | Yes | No | Drug Dependency/Alcohol Abuse | Yes | No |
| Cirrhosis | Yes | No | Depression/Anxiety/Bipolar Disorder | Yes | No |
| Liver Disease | Yes | No | Loose Teeth/Dentures | Yes | No |
| Hepatitis | Yes | No | Previous Blood Transfusion | Yes | No |
| Pancreatitis | Yes | No | Diseases or Problems not listed above | Yes | No |

If you answered yes to any of the above, please explain and list any medications that are being used to treat the condition_____

_____

_____

Have you had previous cosmetic, plastic or reconstructive surgery? Yes No

Type of Surgery_____ Date_____

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever had any other type of surgery? Yes No

Type of Surgery_____ Date_____

_____ _____

_____ _____

_____ _____

_____ _____

Did you experience any complications? Yes No

If yes, please specify_____

Have you ever experienced an adverse reaction to general anesthesia, local anesthesia (Novocain, Xylocaine) or to IV Sedation? Yes No

If yes, please describe the type of reaction_____

**Do you now smoke cigarettes, E- cigarettes, Vape or use tobacco products or have you ever used them? Yes No**

If yes, how much per day?_____For how long?_____

If you quit smoking cigarettes, e-cigarettes, vaping or chewing tobacco when did you quit?_____

*Any patient with a history of smoking will be given a urine test at the preoperative appointment AND the day of surgery to verify that they are nicotine free. **PATIENTS WHO FAIL THEIR NICOTINE TEST WILL HAVE THEIR PROCEDURE CANCELLED AND ARE SUBJECT TO CANCELLATION FEES.**

Do you drink more than 6 cups of coffee per day? Yes No

Do you normally have more than 2 alcoholic drinks per day? Yes No

Have you ever been under the care of a psychologist or psychiatrist? Yes No

If yes, please explain_____

_____

**WOMEN** is there a history of breast cancer in your family? Yes No

If yes, please specify MOTHER'S SIDE:____YES____NO FATHER'S SIDE____YES____NO

____mother ____sister ____mother ____sister

___grandmother ____aunt ____grandmother ____aunt

Have you ever had a mammogram? Yes No

If yes, date of last mammogram_____Location_____

Are you pregnant or trying to become pregnant? Yes No

Do you have heavy menstrual periods? Yes No

When was the first day of your last period?_____

Have you ever had a Tubal Ligation or Hysterectomy? Yes No

Number of Children_____ Number of Pregnancies_____

Number of Children breastfed_____ Date of last breastfeeding_____

**MEN** Do you use sexual performance drugs such as Viagra, Levitra, Cialis? Yes No

Have you in the past or do you currently use steroids? Yes No

Patient's Signature_____Date_____

Physician's signature_____Date_____

**Primary Insurance Carrier:**

Insurance Company Name:_____Insurance Phone Number_____

Address_____

Policy Holder:_____Relationship to Patient: _____

Policy Number:_____Group Number: _____

Subscriber's SS#:_____Subscriber's DOB: _____

Employer's Name:_____

# RELEASE OF INFORMATION

(PLEASE READ EACH CONSENT/AUTHORIZATION BELOW AND SIGN AT THE BOTTOM OF THE PAGE)

**CONSENT FOR PHOTGRAPHIC DOCUMENTATION**

I consent to the taking of photographs of me or parts of my body by Dr. Michael A. Devlin or his designee, as part of my medical record. Preoperative and postoperative photographs of my person will be **used for confidential clinical record purposes only**, (unless specific additional consent is obtained) and shall remain the property of Dr. Michael A. Devlin, M.D.,PLC

**CONSENT FOR COMMUNICATION**

There are many ways to communicate with you. All attempts will be made to preserve your privacy in accordance with HIPPA rules. Please place a check below on all acceptable ways to communicate with you:

_____ Text _____Home _____Email

_____Cell _____Social Media(i.e. Facebook, etc)

_____Work _____Regular Mail

**CONSENT FOR CREDIT CARD, DEBIT CARD AND FINANCING PAYMENTS**

Services that are preformed that are paid for with a credit card, debit card or with financing are not eligible for post-surgical/post-care payment challenges. Devlin Cosmetic Surgery encourages complete post-op care and follow-up interaction to address any issues that may arise. I agree that this credit card, debit card, and financing challenge agreement is irrevocable.

**AUTHORIZATION FOR MEDICAL INFORMATION RELEASE AND CLAIM PAYMENT ASSIGNMENT OF INSURANCE**

I herby authorize Michael A. Devlin, MD to release to my insurance company(ies) any and all information they may require concerning my procedure.

I hereby request and authorize my insurance company (ies) to pay directly to Michael A. Devlin, MD all benefits due under said policy (ies) by reason of services rendered therein.

In making this assignment, I understand and agree that any unpaid balance not covered by my insurance will be paid by me.

A photocopy of this authorization shall be considered as effective and valid as the original.

Signature:_____Date:_____