Quatela
CENTER FOR
PLASTIC SURGERY

PATIENT DEMOGRAPHIC SHEET

Appointment date: _____

Patient name: _____ Birth date: _____Age: _____ Last 4 SS#:_____

Address: _____ City: _____ State: _____ Zip: _____

Race: ☐ Asian/Pacific Islander ☐ African American ☐ Caucasian

☐ Hispanic or Latino ☐ Middle Eastern/Arab ☐ Native American

Ethnicity: _____

Primary Language Spoken: ☐ English ☐ Spanish ☐ French ☐ Other: _____

Contact Information:

May we contact your cell phone? ☐ Yes ☐ No Cell phone: _____

May we contact you at home? ☐ Yes ☐ No Home phone: _____

If yes, may we leave a message? ☐ Yes ☐ No

May we contact you at work? ☐ Yes ☐ No Work phone: _____Ext.____

May we contact you via email? ☐ Yes ☐ No Email address: _____

☐ I am interested in learning about special events and exclusive offers via email (please provide email address).

Employer: _____ Occupation: _____

Employer address: _____ City: _____ State: ____ Zip: _____

Family physician: _____ Phone: _____

Dermatologist: _____ Phone: _____

Emergency contact person: _____ Relationship: _____

Contact address: _____ City: _____ State: ____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

(Please turn over)

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Who referred you to us? Please check any and all that apply.

□ **Physician**
Name: _____

□ **Print Publication**
□ D&C
□ Other_____

□ **Television**
Name of station/channel: _____

□ **Word of mouth/Friend/Staff member**
Name: _____

□ **Seminar**
Title/topic: _____

□ **Radio**
Name of station: _____

□ **Q Med Spa**

□ **Online**
□ Internet search
□ Facebook
□ Other website: _____

□ **Billboard**

□ **Phonebook**

The web is an integral way patients learn about our practice. Do you participate in any of the following? *(Check all that apply)*

□ Google+ □ Yelp □ Facebook □Twitter □ Pinterest □ RealSelf □ Instagram

□ Medical Review Sites: If yes, which one(s)? _____

□ Blogging: If yes, where can we see it? _____

What website(s) did you find helpful in researching our practice or the procedure? _____

FISCAL POLICIES

It is the policy of The Quatela Center for Plastic Surgery that payment for all office services are due on the date of service. We accept various forms of payment including cash, personal checks, money orders, and Visa, MasterCard, Discover, and American Express. According to standard practice, full payment for cosmetic surgery is required three weeks in advance of surgery.

Cancellation of appointments must be made 48 hours prior to scheduled date or service fees will be charged to the patient.

I authorize payment of medical benefits to Vito C. Quatela, M.D. and William J. Koenig, M.D., PLLC for services rendered and release any medical information necessary to process the payment claim.

_____ _____

Signature of Insured or Authorized Person Date

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PATIENT INFORMATION SHEET

Name: _____

Date: _____

Description of facial/body concerns: _____

Is your family/significant other aware of your cosmetic concern(s)? ☐ Yes ☐ No

Does your family/significant other support your desire for cosmetic surgery or enhancement? ☐ Yes ☐ No

Please check any fears you have regarding surgery/medical procedures:

☐ Anesthesia ☐ Surgical outcome ☐ Opinions of others ☐ Unsuccessful past procedures ☐ Pain ☐ Cost

☐ Recovery time ☐ Complications ☐ Natural-looking results ☐ Current medical issues ☐ Other: _____

Please check the strengths you possess that will make this procedure a success for you:

☐ Positive outlook ☐ Personal motivation ☐ Support from significant other ☐ Self-confident

☐ Family support ☐ Successful career ☐ Disciplined, goal-oriented ☐ Confidence in surgeon

☐ Good timing for procedure, i.e.: retirement ☐ Other: _____

Please check the potential opportunities having a procedure/surgery will provide for you:

☐ Improved self-esteem ☐ Improved self-confidence ☐ Advancement in career/career change ☐ Getting married

☐ New relationship opportunities ☐ Correction of cosmetic flaws ☐ Physical appearance reflect mental image of self

☐ Increased comfort with intimacy ☐ Life event, i.e.: child's wedding, school reunion ☐ Other: _____

Are there any other questions or concerns you would like answered at this time?

_____

_____

MEDICAL EVALUATION

Please check <u>all</u> past and present medical conditions.

CARDIOVASCULAR:

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ History of heart attack(s)
- ☐ Atrial fibrillation
- ☐ Heart murmur
- ☐ Peripheral vascular disease
- ☐ Pacemaker
- ☐ Valve disorder
- ☐ History of stroke
- ☐ Angina
- ☐ History of blood clots
- ☐ Congestive heart failure

PULMONARY:

- ☐ Asthma
- ☐ COPD
- ☐ Chronic cough
- ☐ Emphysema
- ☐ Need for supplemental oxygen
- ☐ Sleep apnea/CPAP
- ☐ History of pulmonary embolism

(CONTINUED ON NEXT PAGE)

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HEMATOLOGICAL:

- ☐ Anemia
- ☐ Bleeding/clotting disorder
- ☐ Other hematological

NEUROLOGICAL:

- ☐ Nerve damage
- ☐ Facial paralysis/weakness
- ☐ Epilepsy/seizures
- ☐ Spinal/back disorder
- ☐ Dizziness/vertigo
- ☐ Peripheral neuropathy
- ☐ Migraine headaches

HEPATIC:

- ☐ Cholecystitis
- ☐ Cirrhosis/liver disease
- ☐ Hepatitis
- ☐ Other hepatic

MUSCULOSKELETAL:

- ☐ Muscle weakness
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Degenerative joint disease
- ☐ Osteoporosis
- ☐ Other musculoskeletal

ENDOCRINE:

- ☐ Diabetes
  Type 1 Type 2
- ☐ Insulin dependent
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Other endocrine

EYES/EARS/NOSE/THROAT:

- ☐ Glasses/contacts
- ☐ Blurred/double vision
- ☐ Cornea problems
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Thyroid eye disease
- ☐ Dry eyes
- ☐ Hearing loss – R L
- ☐ Difficulty breathing by nose
- ☐ Nasal allergies
- ☐ Frequent sinus infections
- ☐ Previous nasal injury
- ☐ Dentures/oral appliance

GASTROINTESTINAL:

- ☐ Heartburn/GERD
- ☐ Stomach ulcers
- ☐ Ulcerative colitis
- ☐ Irritable bowel disease
- ☐ Crohn's disease
- ☐ Other gastrointestinal

RENAL/GU:

- ☐ Kidney disease/failure
- ☐ Dialysis
- ☐ Kidney stones
- ☐ Enlarged prostate/prostate disease
- ☐ Other renal/GU

DERMATOLOGICAL:

- ☐ Cold sores/herpes
- ☐ Rosacea
- ☐ Radiation to face/neck
- ☐ Scarring/keloid formation
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis

IMMUNOLOGICAL/ INFECTIOUS DISEASES:

- ☐ Autoimmune disorder: _____
- ☐ Tuberculosis
- ☐ HIV/AIDS
- ☐ STD
- ☐ Other ID/immunological

REPRODUCTIVE:

- ☐ Past pregnancies: # _____
- ☐ C-section
- ☐ Contraception use
  Type: _____
- ☐ Pre/post menopause
- ☐ Other reproductive

PSYCHIATRIC:

- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Claustrophobia
- ☐ Body dysmorphia
- ☐ Receive(d) psychiatric treatment/hospitalization
- ☐ Drug/alcohol dependency
- ☐ Dementia/Alzheimer's
- ☐ Other psychiatric

ONCOLOGICAL:

- ☐ Breast cancer
- ☐ Basal cell cancer
  Site: _____
- ☐ Melanoma
  Site: _____
- ☐ Squamous cell cancer
  Site: _____
- ☐ History of other cancers:
  Site: _____

Review of Systems
Please check yes or no for symptoms in the last six (6) months.

Constitutional	Yes	No	Comment
Fevers			
Chills			
Coughs			
Weight loss			
Weight gain			

HEENT	Yes	No	Comment
Sore throat			
Stiff neck			
Sinus headache			
Nose bleeds			
Ear ache/drainage			
Hearing loss			
Blurred vision or loss			
Itchy/watery eyes			
Wear glasses or contacts			
Dental problems			

Gastrointestinal	Yes	No	Comment
Nausea/vomiting			
Difficulty swallowing			
Constipation			
Diarrhea			
Abdominal pain			
Heart burn			

Urinary	Yes	No	Comment
Pain or burning with urination			
Urinary frequency			
Blood in urine			
Incontinence			

Cardiac	Yes	No	Comment
Chest pain			
Palpitation			
Irregular heartbeat			
Exercise intolerance			
Leg swelling			

Respiratory	Yes	No	Comment
Persistent cough			
Shortness of breath			
Wheezing			
Coughing up blood			
Can’t breathe lying flat			

Skin	Yes	No	Comment
Rash/hives			
Skin discoloration			
Lesions/moles/warts			
Ulcers			
Itching			
Unusual hair loss			
Bruise easily			

Psych	Yes	No	Comment
Depressed mood			
Suicidal thoughts			
Insomnia			
Anxiety			
Frequent crying spells			

Musculoskeletal	Yes	No	Comment
Joint pain			
Muscle weakness			
Back pain			
Muscle spasms/cramps			

Neurologic	Yes	No	Comment
Headaches			
Seizures			
Dizziness			
Limb weakness/numbness			
Tremors			
Syncope (passing out)			

Female Reproductive	Yes	No	Comment
Menstrual pain/cramps			
Have you reached menopause age?			
Bleeding after menopause			
Hot flashes			
Total pregnancies			Delivery dates:
Total miscarriages			

Past Surgical History

List all past surgeries (including cosmetic surgery) with year:

_____ _____ _____

_____ _____ _____

Have you had any surgical complications? ☐ Yes ☐ No

Please describe: _____

_____

Height: _____ Weight: _____ Ideal Weight (if not at ideal): _____

Exercise Frequency (check one): ☐ ≤1x/week ☐ 2-4x/week ☐ 5-7x/week

Marital Status: ☐ Single ☐ Long-term partner ☐ Married ☐ Divorced ☐ Widow(er)

Are you currently pregnant or breastfeeding? ☐ Yes ☐ No

Alcohol Use

- ☐ None
- ☐ Occasionally
- ☐ Daily: How many _____ and what type _____
- ☐ Admits to history of alcoholism

Do you use any nicotine products? ☐ Yes ☐ No If yes, how much per day _____

Did you ever smoke? ☐ Yes ☐ No For how many years: _____ Year you quit: _____

Exposure to 2nd hand smoke on a daily basis? ☐ Yes ☐ No

FAMILY HISTORY

	Condition	Afflicted Family Member(s)	Comments
☐	Adopted		
☐	Abnormal Bleeding/Clotting		
☐	Anesthesia Problems		
☐	Autoimmune Disorders		
☐	Cancer		
☐	Cleft Lip/Palate		
☐	Diabetes		
☐	Hearing Loss		
☐	Heart Disease		
☐	High Blood Pressure		
☐	Kidney Disease		
☐	Liver Disease		
☐	Skin Disease		
☐	Substance Abuse		

Allergies:

_____ _____ _____

_____ _____ _____

Prescription Medications

Medication	Dose	Comments