CHRYSALIS COSMETICS

PATIENT INFORMATION			Date:/
A. Fet all	Fa. 4. 3	.1	
Name: [First]	[M.I.][L	ast]	Male Female
Address:	[Apt.]	Age:	_ D.O.B://
	State: Zip: _		
Social Security #:	Drivers Licen	se #:Home	e Tel:
		Work	: Tel:
		Mobile	:Tel:
E-mail:	@	_	
EMPLOYMENT INFORMAT			
☐ Full Time ☐ Part Time	$ \Box Student \Box Retired \Box$	Other Occupation: _	
Employer/School:		Work Tel:	
EMERGENCY CONTACT			
Name: [First]	[Last]	Hom	ne Tel:
			rk Tel:
Address:		Mobi	le Tel:
City:	State: Zip:		
•	·		
PROCEDURE INFORMATION What is the reason for you FACE Facelift Cheek Lift	BREAST Breast Augmentation Breast Lift (Mastopexy)	BODY Liposuction Tummy Tuck	1
☐ Brow Lift	☐ Breast Revision / Repair	1	☐ Fat Injections
□ Neck Lift	☐ Breast Implant Exchange	Body Lift	Skin Resurfacing
☐ Liquid Facelift	☐ Breast Capsulectomy	☐ Buttock Augmentation	Skin Tightening Laser
☐ Facial Fat Transfer	☐ Breast Reduction	Arm Lift (Brachioplasty)	☐ Hand Rejuvenation
☐ Facial Implants	☐ Breast Asymmetry	☐ Thigh Lift	☐ Hyperhidrosis
☐ Lip Augmentation	☐ Male Breast Surgery	☐ Fat Transfer	☐ Skin Care
☐ Chin Augmentation	Other:	Other:	Other:
☐ Ear Reshaping			
Upper Eyelids			
☐ Lower Eyelids			
Rhinoplasty			
Other:			
Please describe why you a	re interested in having the p	rocedure(s) listed above: _	
Have you consulted with o	ther physicians about proce	dure(s) indicated above? \square	Yes □ No
	n from a previous surgery?		•
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SURGERY SCHEDULING QUESTIONAIRE

To help us understand you What is your time pref		-		=	
HEALTH INFORMATIO	N				
Primary Care Physician		Other Physic	ians:	Weight:	_ Height:
PERSONAL MEDICAL H	<u>IISTORY</u>				
Do you have any chror	nic medical pro	blems? [Fill in box for	those that apply]		
□High Blood Pressure	□Diabetes	□Heart Disease	□Kidney Disease	□Stroke	□Heart Failure
☐ Stomach Problems	□Seizures	□Liver Disease	□Bleeding Problems	s □Emphysema	□Cancer
		□Chest Pain		□Asthma	□HIV or AIDS
□Psychiatric Diagnosis					
Is there a personal or f If yes, please explain?					□No
FAMILY HISTORY					
Do you have a family h	istory of any n	nedical problems?_			
Please indicate Family	member(s):				
Please list all prior Ope			<u>List any compli</u>		
1					
2					
3		//			
Please list all prior Hos	pitalizations:	<u>Date</u>	List any complic	ations:	
1		//			
2					
3		//			
Please list ALL CURREN	IT medications	and/or dietary sup	plements including:		
(Prescriptions, Over th	e Counter Med	dicines, Aspirin, Vita	amins, and Herbal Sup	oplements)	
1		6.	·		
2					
3			·		
4					
5)		
Please list ALL allergies			ifish, Latex, Penicillin,		
SOCIAL HISTORY					
Do you use Blood Thin	ners? (i.e.Coum	adin/Heparin/Ibuprofe	n) □ Yes □ No If	Yes, medication i	name:
Have you used Diet Pil	ls in the last tw	vo (2) weeks?	□ Yes □ No If	Yes, medication i	name:
Have you taken Steroid	ds / Accutana	within the last vear	? ¬Vos I ¬No If	Vas madication n	iame:

	cco/Hookah/Vape products? Yes	No If Yes, How many/how long:
Do you use Recreational Dru	gs? □ Yes □ No If Yes, list type:	
FEMALE QUESTIONNARE		
Female Gynecological Histor	y: Have you had had any previous pregn	ancies? 🗆 Yes 🗆 No #
Do you plan on having any o	r any more children? □ Yes □ No	
Have you had a mammograr	m in the last year? If Yes, date of exam:	/Normal or Abnormal
in your experience. Dr. Perry privacy and the confidential federal regulations regarding Insurance Privacy and Protectopy of the "Notice of Privacy Your PHI, also known as you Basis for planning your care Means of communication Bears of which you or a text A tool in educating health A source of data for medical A source of information for A tool with which we can acknow The "Notice of Privacy Practe How we may use/disclose How you may request cope How you may request an action of the How you have you may request an action of the How you have you may request you have you	r privacy is a very important part of our mand his staff adhere to the highest stand ty of your health care information. Addit g the privacy of individual health care information Act), enacted on April 14, 2003. We by Practices" regarding your Personal Health or medical record, serves as at e and treatment and post-surgical care among the many health professionals while the care you received hird-party payer can verify that services by professionals all research republic health officials charged with impossess and continually work to improve the sices" details the following: Your PHI to carry out treatment, payment is of your healthcare information. Curacy of this information. Curacy of this information. Curacy of this information to another entitle of the content of the	are required by law to have available, a lth Information (PHI). o contribute to your care billed were provided roving the health of this state and the nation are care we render and the outcomes we to rhealth care operations. of your PHI. or health care operations, it may become tity, and I consent to such disclosure for
Print Name	 Signature	/ Date
List of HIPAA approved indiv	iduals to aid in my care:	