

PATIENT INFORMATION

Today's Date: _____
Patient Name: _____ Age: _____ Birthdate: _____
Last First Middle

Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____

E-mail Address: _____

Would you like to receive our newsletter? [] Yes [] No

Which of the following most accurately describes you?

[] Female [] Male [] Non-Binary [] Transgender [] Intersex [] Other

Legal Status:

[] Child [] Single [] Divorced [] Married [] Other

Race: _____ Ethnicity: _____ Language: _____

Patient's Employer: _____ Occupation: _____

Reason for Visit: _____

Referred by: [] Physician Phone: _____
[] Previous Patient
[] Internet (what site?)
[] Magazine
[] Insurance Company
[] Other

Are you interested in other services:

[] Skincare products [] Botox [] Chemical Peels
[] Miradry [] Fillers [] Sofwave
[] FemTouch [] Accupulse [] Other

Emergency Contact: _____ Phone: _____
Name (Last, First)

Relationship: _____

Responsible Party: [] Same as above

Patient Name: _____ Age: _____ Birthdate: _____
Last First Middle

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

Home Phone: _____ Work Phone: _____ Cell: _____

BAJAJ PLASTIC SURGERY

PATIENT HEALTH HISTORY



To your knowledge, do you have or have you ever had any of the following:

Respiratory	Y	N	Neurologic	Y	N	Hematologic	Y	N
Recent cold. Bronchitis or Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA/Mini-Stroke	<input type="checkbox"/>	<input type="checkbox"/>	History of Anemia (low blood count)	<input type="checkbox"/>	<input type="checkbox"/>
History of Asthma or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis or Polio	<input type="checkbox"/>	<input type="checkbox"/>	Sickle-Cell Anemia/Trait	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or Silicosis	<input type="checkbox"/>	<input type="checkbox"/>	Weakness or Paralysis (Temporary or Permanent)	<input type="checkbox"/>	<input type="checkbox"/>	History of Bleeding or Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea/Excessive Snoring	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath at Rest	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis/Blood Clots/DVTs/Factor V Leiden/ Anti-Phospholipid Antibody	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath with Limited Exercise or at Night	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough or Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Skin	Y	N	Gastrointestinal	Y	N	Other	Y	N
Fragile/Burns easily	<input type="checkbox"/>	<input type="checkbox"/>	GI Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Back Problems	<input type="checkbox"/>	<input type="checkbox"/>
MRSA	<input type="checkbox"/>	<input type="checkbox"/>	GI bleed; ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Any Loose /Chipped Teeth	<input type="checkbox"/>	<input type="checkbox"/>
History of cold sores	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/Jaundice/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Temporal Mandibular Joint Disease	<input type="checkbox"/>	<input type="checkbox"/>
Keloids (thick scars)	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis (curvature of spine)	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Heartburn/GERD	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	Y	N	Eyes	Y	N	Cardiovascular	Y	N
Adrenal Gland Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Urology	Y	N	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health	Y	N	Urinary Issues (Retention, Incontinence, Frequency)	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Renal/Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Issues	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
			Breast	Y	N	Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
			Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Chest Discomfort or Tightness	<input type="checkbox"/>	<input type="checkbox"/>
						Poor circulation to feet/legs	<input type="checkbox"/>	<input type="checkbox"/>

Complete this section **ONLY** if you answered **yes** to any cardiovascular problems

An exam by a cardiologist (Heart doctor)			If yes, Dr.'s Name:	City:	Phone:()
Electrocardiogram (EKG)			If yes, where most recently		Year
Heart Catheterization			If yes, where most recently		Year
Exercise Stress Test			If yes, where most recently		Year
Ultrasound of Heart (Echocardiogram)			If yes, where most recently		Year
Pacemaker			If yes, Dr.'s Name:	City:	Phone:()

List any active medical problems you have:

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For Women Only

BREAST/FEMALE HISTORY

Are you pregnant? Yes No Date of last menstrual period: _____

Do you have a gynecologist/OB/GYN? Yes No

Name of physician/facility: _____

Breast Symptoms (if applicable):

- | | | |
|--|--|---|
| <input type="checkbox"/> Unsatisfactory Appearance | <input type="checkbox"/> Breast Pain | <input type="checkbox"/> Nipple Discharge |
| <input type="checkbox"/> Implant Problems | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Absence of Breast/Nipple | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Breast Mass/Lump |

Breast Cancer Treatment:

Radiation Therapy Yes No Date Completed _____

Chemotherapy Yes No Date Completed _____

Other: _____

Mammograms:

Date _____ Location _____

Findings _____

Breast Implants:

Do you currently have implants? Yes No

Saline Silicone Size in CC's:

Under muscle Over muscle

Manufacturer: _____

Date of last pelvic exam: _____

How many children have you had? _____ Breast fed? Yes No

History of miscarriages? Yes No

History of infertility? Yes No

Do you have concerns regarding vaginal laxity? Yes No

Do you have concerns regarding urinary incontinence? Yes No

Do you have concerns regarding the external appearance of your labia? Yes No

If you selected YES for the three previous questions please describe:

History of taking hormones? Yes No

Please list names: _____

History of birth control (any kind) Yes No

Please list names: _____

	Y	N
Have you taken any Aspirin or Aspirin-like products (Motrin, Advil, Nuprin, etc.) in the last 10 days?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medications did you take:		
Do you have any medication allergies	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please list allergies and reactions:		
Check if you are allergic to: <input type="checkbox"/> Latex <input type="checkbox"/> Contrast Dye <input type="checkbox"/> Adhesive Tape <input type="checkbox"/> Iodine <input type="checkbox"/> Other:		
Do you or have you ever taken Accutane?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, when did you stop?		

MEDICATIONS

(Please list all prescription, over-the-counter medications, vitamins/minerals. Include all blood thinners, Aspirin, Ibuprofen, Bufferin, birth control pills, diuretics, blood pressure or heart medications, tranquilizers, hormones, etc. *Please list even if you do not take on a daily basis.)

Medication	Dose	Frequency	Last Taken	Reason for Taking	Comments

Please list all supplements and herbal medications

Medication	Dose	Frequency	Last Taken	Reason for Taking	Comments

Please list all recreational drugs used including marijuana and edibles

Medication	Dose	Frequency	Last Taken	Reason for Taking	Comments

PHARMACY INFORMATION

Name _____
 Address _____
 Phone _____

Please list all previous surgeries (including cosmetic, childbirth, medical illness)

Date (year)	Reason/Procedure	Place (hospital or city)	Anesthesia	Surgeon

Anesthesia Complications after Surgery Yes No

If yes, please specify:

- Muscle Weakness
- Jaundice
- Breathing Problems
- Unexpected Fevers
- Allergic Reaction
- Difficulty waking up
- Nausea
- Vomiting
- Sensitivity to Anesthesia Agent
- Other: _____

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Please list all previous hospitalizations (including childbirth and medical illness)

Date (year)	Reason	Place (hospital or city)	Anesthesia	Surgeon

Please list all previous cosmetic treatments

Date (year)	Treatment/Procedure	Place/Provider	Number of Treatments

If you are interested in skincare services, please fill in the below:

What is your current skincare regimen?

What skin concerns do you have?

Please list all previous skincare treatments

Date (year)	Treatment/Product	Place/Provider	Number of Treatments

GENERAL HEALTH Good Fair Poor

If not good, please explain:

Height _____ Weight _____

Last Physical Exam: _____

Do you have a Primary Care Physician? Yes No

Name and Address of Doctor/Facility: _____

Have you had a recent pneumonia vaccine? Yes No

Have you received the COVID-19 vaccine? Yes No

SOCIAL HISTORY

Do you Drink? Yes No How Often: _____

Do you Smoke? Yes No How Much: _____

Do you use E-Cigarettes or Vape? Yes No How Often: _____

Do you use any other nicotine products (including replacement therapy like gum/patch)? Yes No

What? _____

Do you use recreational drugs? Yes No How Often: _____

Do you exercise? Yes No How Often: _____

FAMILY HISTORY Have any of your blood relatives had, if yes, please indicate the relationship

- Abnormal clotting
- Auto Immune Disorder
- Breast Cancer
- Diabetes
- Drug Allergies
- Heart Disease
- Hemophilia
- Kidney Disease
- Liver Disease
- Lung Disease
- Malignant Hypothermia
- Skin Cancer
- Substance Abuse
- Von Willebrand

Patient Signature

Date

DISCLOSURE OF PROTECTED HEALTH AND FINANCIAL INFORMATION TO INDIVIDUALS OTHER THAN THE PATIENT PURSUANT TO AN AUTHORIZATION

It is the policy of **BAJAJ PLASTIC SURGERY** to protect the confidentiality, integrity and security of protected health information ("PHI") contained in patient medical and billing records and to comply with legal standards governing the use or disclosure of such information. This policy applies to all records which contain PHI regardless of the form or medium in which it is maintained. Patient medical and billing records may be used by or disclosed to individuals or entities other than the patient pursuant to the patient's authorization.

Name of Patient: _____
Date of Birth: _____ SSN: _____

My Authorization:

I authorize **BAJAJ PLASTIC SURGERY** to disclose my health and financial information to the following recipient(s):

Name / Relationship _____
Address _____
City _____ State _____ Zip _____
Phone Number _____

Name / Relationship _____
Address _____
City _____ State _____ Zip _____
Phone Number _____

Name / Relationship _____
Address _____
City _____ State _____ Zip _____
Phone Number _____

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission
I understand that uses and disclosures already made based upon my original permission cannot be taken back.

Patient Signature

Date

**PATIENT CONSENT FOR USE OF CREDIT CARDS, DEBIT CARD, AND FINANCING –
DISCLOSURE OF PROTECTED HEALTH INFORMATION**

It may become necessary to release your protected health information to financial parties, credit card entities, banks and financing companies, when requested, to facilitate your payment.

Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Bajaj Plastic Surgery to use and disclose my protected health information to any credit card entity, bank, or financing company when they request such information to process an account and assist with payment.

* _____ I will not challenge such credit, debit or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

* _____ I agree that this non credit card challenge agreement is irrevocable.

Patient Signature

Date

Print Name

COVID-19 PANDEMIC -BRIEF PATIENT CONSENT

I understand there is currently a COVID-19 (coronavirus) pandemic. No one truly understands how many persons have been infected and are carriers of COVID-19. At this time, a 100% guaranteed COVID-19 safe environment is not possible. I understand that the staff and office will be taking all efforts to prevent all patients from contracting the illness. But, eve with diligent efforts, these efforts cannot prevent all cases and some patients are likely infected, but asymptomatic, before they even arrive at a health care facility. I understand the health care providers of this facility will do their best to prevent my acquiring or developing a COVID-19 infection. I accept that I am entering the office for a procedure, follow-up appointment or consultation at my own risk. I accept these visits are considered elective and I was given the option to defer my visit to a later date. I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my visits at the office and in the near future during this pandemic.

Patient Signature

Date

Print Name

SMOKING POLICY

At Bajaj Plastic Surgery, your health and well-being are very important to us, and we hope to make your surgical experience as smooth as possible. For this reason, **SMOKING IS ABSOLUTELY PROHIBITED BOTH BEFORE AND AFTER SURGERY.**

Smoking can cause delayed wound healing, death of skin or tissue and increased risk of infection. Please also be aware that second-hand smoke (other people smoking in your home) and use of nicotine products (nicotine gum, nicotine patches, and e-cigarettes) can cause the same problems.

Smoking constricts your blood vessels and inhibits the binding of oxygen, which reduces the amount of oxygen that is available to your cells. Without sufficient oxygen, you won't heal as well after your surgery. Risks of poor healing include skin necrosis (skin death), raised red scars, and wound separation. Individuals who smoke can have a fourfold increase of surgical infections compared with non-smokers. Smokers are also more likely to experience anesthesia complications and develop infections after surgery.

We require that all of our patients quit smoking a minimum of 4 weeks before surgery and 4 weeks after surgery. Any patient with a history of smoking will be given a urine test at their pre-operative appointment and the day of surgery to verify that they are smoke free. **PATIENTS WHO FAIL TO STOP SMOKING WILL HAVE THEIR PROCEDURE CANCELLED AND WILL FORFEIT THEIR SURGERY DEPOSIT.**

Our policies may appear to be quite strict, but your health and safety is very important to us. We want your recovery to be smooth and uneventful.

Please do not hesitate to call us at any time if you have any questions or require additional information. Thank you for choosing us to provide your plastic surgery care. We are committed to providing you with the optimal surgical experience.

Patient Signature

Date

PATIENT SWEAT ASSESSMENT QUESTIONNAIRE/INTAKE FORM

We strive to offer innovative technologies and services to benefit our patients. We now offer an aesthetic procedure that eliminates underarm sweat glands. The MiraDry® procedure reduces underarm sweat and odor in a simple office treatment.

If you have interest in this procedure, please take a moment to answer the following questions about your experience and feelings regarding underarm sweat. This will help us better understand your needs.

Please check the statements below that describe your experiences with underarm sweat:

1. Check the box for each situation you have experienced.
2. Indicate how much each situation bothers you, using a score of 1-10, where 10 = bothers you a lot and 1 = doesn't bother you much.

Check if you have experienced with each sweat situation:	Does this bother you? 10 = Bothers me a lot 1 = Doesn't bother me much
<input type="checkbox"/> Visible underarm wetness during a business or social situation	_____
<input type="checkbox"/> Stains in clothing due to sweat and use of deodorants or antiperspirants	_____
<input type="checkbox"/> Lingering odor in clothing	_____
<input type="checkbox"/> White streaks on dark clothing from deodorant/antiperspirant	_____
<input type="checkbox"/> Frequent dry cleaning due to odor or stains	_____
<input type="checkbox"/> Dislike daily use of chemicals/deodorants/antiperspirants	_____
<input type="checkbox"/> That not-so-fresh feeling during the day	_____

