

# HISTORY INTAKE FORM

**Patient Name:** \_\_\_\_\_ **Birth Date:** \_\_\_/\_\_\_/\_\_\_

Please answer all of the questions as accurately as possible. If you do not understand the question please ask for assistance.

## CURRENT MEDICAL HISTORY:

Have you or any member of your family ever had a problem with anesthesia? YES NO

Are you allergic to any medication or substance (food, environment, or latex)? Please list them:

Please list any medications you are presently taking including over the counter, prescription, herbs or vitamins \_\_\_\_\_

List previous surgeries or major illnesses and dates: \_\_\_\_\_

## PERSONAL HISTORY:

**Do you:**

Smoke YES NO \_\_\_\_\_ Pkgs/Day

If former smoker, date quit: \_\_\_\_\_

Drink caffeine YES NO \_\_\_\_\_ Amount/Day

Drink alcohol YES NO \_\_\_\_\_ Day/Week

**Current:**

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

## WOMEN ONLY:

Age period began \_\_\_\_\_

Number of pregnancies \_\_\_\_\_

Date of last mammogram \_\_\_\_\_

Did you breast feed? YES NO

Do you do regular breast self-exams? YES NO Breast lump or discharge YES NO

## FAMILY HISTORY:

Has any blood relative ever had the following?

Breast Cancer....YES NO High blood pressure.... YES NO Kidney Disease.. YES NO

Melanoma..... YES NO Heart Disease..... YES NO Depression..... YES NO

Stroke..... YES NO Diabetes..... YES NO Blood Clots..... YES NO

## PAST MEDICAL HISTORY:

Have you ever had the following?

Heart Disease.... YES NO Cancer..... YES NO Stomach Ulcer.....YES NO

Arthritis..... YES NO Glaucoma..... YES NO Kidney Disease.....YES NO

Rheumatic Fever..YES NO Asthma..... YES NO Thyroid Disease.....YES NO

Anemia..... YES NO AIDS or HIV..YES NO Bleeding Tendency...YES NO

Tuberculosis..... YES NO Stroke.....YES NO High Blood Pressure..YES NO

Diabetes..... YES NO Hepatitis.....YES NO Blood Clots..... YES NO

## REVIEW OF SYSTEMS:

Do you have now or have you had within the past year:

Weight Change....YES NO Swollen feet/ankles.... YES NO Seizures.....YES NO

Dry Eyes.....YES NO Skin rash.....YES NO Joint or muscle pain...YES NO

Chronic Cough....YES NO Chronic Diarrhea.....YES NO Swollen lymph nodes..YES NO

Chest Pain.....YES NO Jaundice..... YES NO Easy bleeding.....YES NO

Rapid Heart Beat...YES NO Depression.....YES NO Easy bruising.....YES NO

**I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.**

X \_\_\_\_\_ **DATE:** \_\_\_/\_\_\_/\_\_\_

Signature of patient or parent if minor

Women's Skin Evaluation  
**FVPS MEDICAL DAY SPA SKIN EVALUATION**

Name: \_\_\_\_\_ Birthdate: \_\_/\_\_/\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email address: \_\_\_\_\_  
Are you interested in receiving periodic emails on news, sales, etc.? YES \_\_\_ NO \_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
May we contact you at Home \_\_\_\_\_ Work \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

Have you ever seen a Dermatologist for your skin? YES NO  
Have you previously had: Chemical Peel YES NO  
Laser Resurfacing or Microdermabrasion YES NO  
Facial Surgery YES NO  
Have you done any aggressive exfoliation to your skin in the last 2 weeks? YES NO

**Home Skin Care Products:**

Cleanser \_\_\_\_\_ Toner \_\_\_\_\_ Exfoliator \_\_\_\_\_  
Moisturizer \_\_\_\_\_ Eye Cream \_\_\_\_\_ Sunscreen \_\_\_\_\_  
Make-up brand \_\_\_\_\_

Are you taking Accutane? YES NO  
Have you ever taken Accutane? YES NO  
What topical medications do you use or have you used? Please check all that apply  
Retin A \_\_\_\_\_ Glycolic Acid \_\_\_\_\_ Other \_\_\_\_\_  
Have you ever used a topical fluorouracil (i.e. Effudex) preparation on your skin?  
If Yes, when? \_\_\_\_\_ On what area of body? \_\_\_\_\_

Please list any oral medications you currently take:

\_\_\_\_\_

Please list any nutritional supplements you take: \_\_\_\_\_

**Hypersensitivity and Fragility:**

Have you ever had a skin allergy? YES NO  
Are you allergic to: Cosmetics YES NO Fabrics YES NO  
Aspirin YES NO Other YES NO  
Do you have any known allergies: YES NO  
If yes, please list: \_\_\_\_\_  
Do you "flush" or "appear reddened" easily when you eat spicy food, drink alcohol, get angry, go in the sun, etc.? YES NO

**Free Radical Exposures:**

Do you smoke?	YES	NO	
Do you have a healthy diet?	YES	NO	
Do you exercise?	YES	NO	
Do you take vitamins?	YES	NO	
Permanent Make-up?	YES	NO	Areas: _____

**Hormones:**

Do you have regular periods?	YES	NO
Are you going through menopause?	YES	NO
Are you pregnant or lactating?	YES	NO
Are you trying to become pregnant?	YES	NO
During pregnancy did you get hyperpigmented?	YES	NO

**Vascularity (telangiectasia or broken capillaries): CIRCLE THE FOLLOWING**

Nose area	Cheek area	Chin area	Forehead	Entire Face
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**Acne: CIRCLE THE FOLLOWING**

Do you have any history of acne or periodic breakout?	YES	NO	
Pimples	White heads	Blackheads	Cysts
Enlarged Pores	Acne scars	Flakiness	
Do you only experience breakout during or around your menstrual cycle?	YES	NO	
Do you always have a pimple or some type of breakout?	YES	NO	

**Facial Wrinkles: CIRCLE THE FOLLOWING**

Deep wrinkles	Crows feet	Fine lines			
Have you been treated with Botox?	YES	NO	Collagen/Cymetra?	YES	NO

**Skin type: CIRCLE THE FOLLOWING**

Does your skin ever flake or feel tight and dry? Frequent /Occasional /Very Rare  
 Is your skin ever shiny a few hours after cleansing? Frequent/ Occasional/ Very Rare  
 How often do you experience blackheads or blemishes? Frequent / Occasional/ Very Rare  
 How noticeable are your pores? Very / T-zone/ Not very

**Ability to heal:**

Does your skin appear fragile or burn easy?	YES	NO
Do you form thick or raised scarring from a cut or burn?	YES	NO
Do you have a pace maker?	YES	NO
Do you wax or use depilatories on your face?	YES	NO
Do you ever get cold sores?	YES	NO

**Sun History and Lifestyle:**

Do you work inside?	YES	NO
Are your hobbies done mostly outside?	YES	NO
In the past (including childhood) did you live in the sunbelt?	YES	NO
In the past have you neglected to use a sunscreen when outdoors?	YES	NO

Do you ever use tanning beds? YES NO  
 Do you currently wear a sun protection product all day, everyday? YES NO  
 Are you willing to wear a sun protection product all day, everyday? YES NO  
 Have you or any member of your family ever had skin cancer? YES NO  
 Location of skin cancer? \_\_\_\_\_

How do you want to improve your skin?  
 1) \_\_\_\_\_  
 2) \_\_\_\_\_  
 3) \_\_\_\_\_

What specific areas do you want to treat?  
 Neck Face Chest Back Other \_\_\_\_\_  
 Do you wear contact lenses? YES NO

Patient Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**FOR OFFICE USE ONLY: Patient Skin Analysis**

Oily X-Dry Dry Normal Combination  
 Thick Thin Normal Other  
 Wrinkles \_\_\_\_\_ Fine \_\_\_\_\_ Deep \_\_\_\_\_ Acne \_\_\_\_\_ Type \_\_\_\_\_ Scars \_\_\_\_\_  
 Other scarring \_\_\_\_\_  
 Keloids \_\_\_\_\_ Scarring \_\_\_\_\_ Pigmentation \_\_\_\_\_  
 Telangiectasias \_\_\_\_\_ Milia \_\_\_\_\_  
 Comedones \_\_\_\_\_ Keratosis \_\_\_\_\_

**Skin Color Analysis:**

Caucasian	light	medium	dark	very dark
African American	light	medium	dark	very dark
Asian	light	medium	dark	very dark
Indian	light	medium	dark	very dark
Hispanic	light	medium	dark	very dark
Ethnic Combination	light	medium	dark	very dark

**FOX VALLEY PLASTIC SURGERY SKIN CARE  
SKIN EVALUATION FOR MEN**

Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Have you ever seen a Dermatologist for your skin?      Y      N

Are you taking Accutane?      Y      N

Have you ever taken Accutane?      Y      N

What topical medications do you or have you used?

RetinA \_\_\_\_\_ Glycolic Acid \_\_\_\_\_ Other \_\_\_\_\_

What oral medications do you use or have you used?

Antibiotics \_\_\_\_\_ Other \_\_\_\_\_

Hypersensitivity:

Have you ever had a skin allergy?      Y      N

Are you allergic to: Fabrics \_\_\_\_\_ Aspirin \_\_\_\_\_

Other \_\_\_\_\_

Free radical exposure:

Do you smoke?      Y      N      How often? \_\_\_\_\_

Do you consume alcohol?      Y      N      How often? \_\_\_\_\_

Do you have a regular diet?      Y      N      How often? \_\_\_\_\_

Do you exercise?      Y      N      How often? \_\_\_\_\_

Do you take vitamins?      Y      N      How often? \_\_\_\_\_

Pigmentation:

How do you tan? Burn \_\_\_\_\_ Usually Burn \_\_\_\_\_ Sometimes Burn \_\_\_\_\_  
Never Burn \_\_\_\_\_

Pigmentation: Even \_\_\_\_\_ Uneven \_\_\_\_\_ Birthmark \_\_\_\_\_

Vasularity:

Broken Capillaries: Nose area \_\_\_\_\_ Cheek area \_\_\_\_\_ Chin area \_\_\_\_\_

Forehead area \_\_\_\_\_ Entire face \_\_\_\_\_

Acne:

Do you have any history of acne or periodic breakout? Y N  
Pimples \_\_\_\_\_ Whiteheads \_\_\_\_\_ Blackheads \_\_\_\_\_ Enlarged Pores \_\_\_\_\_  
Acne scars \_\_\_\_\_ Cysts \_\_\_\_\_ Flakiness \_\_\_\_\_

Facial Wrinkles:

Deep wrinkles \_\_\_\_\_ Crows feet \_\_\_\_\_ Fine lines \_\_\_\_\_

Skin type: F= Frequency O=Occasionally V=Very Rarely

Does your skin ever flake or feel tight and dry? \_\_\_\_\_  
Is your skin ever shiny a few hours after cleansing? \_\_\_\_\_  
How often do you experience blackheads or blemishes? \_\_\_\_\_  
How noticeable are your pores? \_\_\_\_\_

Ability to heal:

Does your skin appear fragile or burn easy? Y N  
Do you form thick or raised scarring from a cut or burn? Y N  
Do you have any health problems? Y N  
Do you ever get cold sores? Y N

Sun History and Lifestyle:

What percentage of time do you spend in the sun? Summer \_\_\_\_ Winter \_\_\_\_  
In the past, did you live in the sunbelt and sunbathe? \_\_\_\_\_  
In the past, have you neglected to use sunblock when outdoors? \_\_\_\_\_  
Have you or any member of your family ever had skin cancer? \_\_\_\_\_  
Location: \_\_\_\_\_

How do you want to improve your skin?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**RENAISSANCE DAY SPA CANCELLATION POLICY**

The Renaissance Day Spa reserves a time especially for you to be pampered and taken care of in a special way. We would appreciate a timely cancellation call if you are not able to keep your scheduled appointment with our qualified staff.

If you must cancel or change your spa appointment, please notify us at least 24 hours prior to your appointment time in order to avoid being charged a \$30 service fee. No shows will be charged 50% of the treatment value. Please note that if you arrive late for your treatment, it will end as scheduled so as not to delay the next scheduled client.

**I UNDERSTAND THE RENAISSANCE DAY SPA CANCELLATION POLICY**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

**This notice describes how Fox Valley Plastic Surgery may use and disclose your healthcare information and how you can obtain access to this information. Please review it carefully.**

Fox Valley Plastic Surgery is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Fox Valley Plastic Surgery or received by Fox Valley Plastic Surgery from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Fox Valley Plastic Surgery will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.

Fox Valley Plastic Surgery reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

### Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

Fox Valley Plastic Surgery may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations.

#### Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, Fox Valley Plastic Surgery may determine that you require the services of a specialist. In referring you to another doctor, Fox Valley Plastic Surgery may share or transfer your healthcare information to that doctor.

#### Payment activities may include:

- Activities undertaken by Fox Valley Plastic Surgery to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, Fox Valley Plastic Surgery will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, Fox Valley Plastic Surgery may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Fox Valley Plastic Surgery may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a patient, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Fox Valley Plastic Surgery is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- **As permitted or required by law.**  
In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.
- **For public health activities.**  
We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency.  
We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child. We may release healthcare records, to the Food and Drug Administration when required by federal law. We may disclose healthcare records for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.
- **For health oversight activities.**  
We may disclose healthcare records in response to written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification.
- **Judicial and Administrative Proceedings.**  
Patient healthcare records may be disclosed pursuant to a lawsuit court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records.

- For activities related to death.  
We may disclose patient healthcare records to a coroner or medical examiner for purpose of completing a medical certificate or investigating a death.
- For research.  
Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.
- To avoid a serious threat to health or safety.  
We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.
- For workers compensation.  
We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Fox Valley Plastic Surgery will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Fox Valley Plastic Surgery has taken action in reliance thereon. Any revocation must be in writing.

#### Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Fox Valley Plastic Surgery to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Fox Valley Plastic Surgery may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Fox Valley Plastic Surgery send protected health information, including billing information, to you by alternative means or to alternative locations. You also request that Fox Valley Plastic Surgery not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Fox Valley Plastic Surgery amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Fox Valley Plastic Surgery for the six years prior to the date of the request, beginning with disclosures made after April 14<sup>th</sup>, 2003. We are not required, however, to record disclosures we make pursuant to signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Fox Valley Plastic Surgery and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Fox Valley Plastic Surgery, please contact the Privacy Officer at the following:

Privacy Officer  
Fox Valley Plastic Surgery  
2400 Witzel Ave Ste. A  
Oshkosh, WI 54904  
(920) 233-1540

It is the policy of Fox Valley Plastic Surgery that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

**Fox Valley Plastic Surgery**  
**Written Acknowledgement of Receipt**

I, \_\_\_\_\_, acknowledge that I have received the written Notice of Privacy Practices from Fox Valley Plastic Surgery.

\_\_\_\_\_  
(Patient or Personal Representative Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Patient or Personal Representative Signature)

\_\_\_\_\_  
(Date)

The patient's condition prohibits the individual from signing an acknowledgement at the time. It will be obtained as reasonably practicable after the patient's condition improves.

Acknowledgment was unable to be obtained.

Reason: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Employee Signature)

\_\_\_\_\_  
(Date)