MICHAEL J PACIOREK MD
Facial Plastic Surgery

COSMETIC SURGERY PATIENT HEALTH HISTORY

Patient Name _____ Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip _____ E-Mail _____

Phone (home) _____ Phone (work) _____ Phone (cell) _____

Marital Status (circle one) Single / Married / Separated / Divorced / Widow SS# _____

Emergency Contact _____ Phone _____ Relationship _____

Family Physician _____ Phone _____ City / State _____

Pharmacy _____ Phone _____

Do we have permission to obtain additional health information from your family physician? ❒ Yes ❒ No

Medication Allergies
Please list any medication allergies and reactions that you my have

Medications
Please list all medications that you are taking

Past Surgical History
Please list any surgeries you have had

Please check the procedure(s) in which you are interested.

__QuickLift ™
__Neck Liposuction
__Botox Injection
__Brow Lift
__Eyelid Surgery
__Rhinoplasty
__Full Face Lift
__Chemical Peel
__ Fillers (Juvederm, Radiesse, Restylane)
__ Skin Care
__ Other

How did you hear about us? _____

When did you first consider cosmetic surgery? _____

Have you consulted with another doctor? ❒ Yes ❒ No

Have you ever had local anesthesia (Novocain, Xylocaine, etc) by a dentist or doctor? ❒ Yes ❒ No

Have you ever experienced an adverse reaction to anesthesia? ❒ Yes ❒ No

If yes, please describe the type of reaction _____

PLEASE CHECK ALL THAT APPLY TO YOU CURRENTLY OR IN THE PAST.

Allergies	❒ Yes ❒ No	High / Low Blood Pressure	❒ Yes ❒ No
Hay Fever	❒ Yes ❒ No	Kidney Disease	❒ Yes ❒ No
Nasal Allergies	❒ Yes ❒ No	Bladder Disease	❒ Yes ❒ No
Asthma	❒ Yes ❒ No	Arthritis	❒ Yes ❒ No
Vision / Eyes	❒ Yes ❒ No	Decreased circulation (fingers/toes)	❒ Yes ❒ No
Chest Pains	❒ Yes ❒ No	Skin Infections	❒ Yes ❒ No
Stomach Ulcers	❒ Yes ❒ No	Skin Irritations	❒ Yes ❒ No
Lung Disease	❒ Yes ❒ No	Skin Rashes	❒ Yes ❒ No
Liver Disease	❒ Yes ❒ No	Herpes	❒ Yes ❒ No
Gall Bladder Disease	❒ Yes ❒ No	HIV/Aids	❒ Yes ❒ No
Yellow Jaundice	❒ Yes ❒ No	Sexually Transmitted Disease	❒ Yes ❒ No
Severe Headaches	❒ Yes ❒ No	Seizures	❒ Yes ❒ No
Dizzy Spells	❒ Yes ❒ No	Depression	❒ Yes ❒ No
Paralysis/Numbness	❒ Yes ❒ No	Mitral Valve Prolapse	❒ Yes ❒ No
Bruise Easily	❒ Yes ❒ No	Autoimmune Disease (Lupus, MS)	❒ Yes ❒ No

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

_____

_____

_____

Family History Please list all medical illnesses effecting your immediate family

Family Member	Age	Living	Deceased	Medical Problems
Mother				
Father				
Other				

_____

_____

Social History

Occupation/Previous Occupation _____

Do you live alone?	❒ Yes ❒ No
Do you smoke cigarettes or chew tobacco?	❒ Yes ❒ No
Do you drink alcohol?	❒ Yes ❒ No
Do you use recreational drugs?	❒ Yes ❒ No
Have you ever been under the care of a psychologist or psychiatrist?	❒ Yes ❒ No

If yes, please explain _____

_____

_____

_____

Patient's signature _____ Date _____

Physician's signature _____ Date _____

Reviewed by _____ Date _____

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Dr. Paciorek is required by law to protect the privacy of your health information and to provide you with a copy of our Privacy Notice. This Notice describes the ways we will use and disclose your health information. This Notice also describes your rights and our obligations regarding your health information. A copy of our current Notice will be available in our reception area.

Your privacy is paramount to this office. In order to guard your health information, please indicate your authorization below.

I _____, authorize Dr. Paciorek's staff to leave appointment information on:

On Home Phone (Include Auto Call)	Yes	No
On Cell Phone (Include Auto Call)	Yes	No
Mobile Text (include Auto Call)	Yes	No
On Office Voice Mail?	Yes	No
w/ Another Person?	Yes	No
Send via mail (Include Reminder Cards)	Yes	No
Send Via E-mail/Portal	Yes	No

Email Address: _____

I _____, authorize Dr. Paciorek's staff to leave medical information on:

On Home Phone (Include Auto Call)	Yes	No
On Cell Phone (Include Auto Call)	Yes	No
Mobile Text (include Auto Call)	Yes	No
On Office Voice Mail?	Yes	No
w/ Another Person?	Yes	No
Send via mail	Yes	No
Send Via E-mail /Portal	Yes	No

Please list persons authorized to discuss my medical information and appointments with:

_____

I acknowledge receipt of Dr. Michael Paciorek's Privacy Policy

Signature_____Date_____

MICHAEL J PACIOREK MD
Facial Plastic Surgery

Photographic Release Form

Record of Authorization for Taking and Publication of Photographs

In connection with the medical services, which I am receiving from my physician, Dr. Paciorek, I consent that photographs may be taken of me of parts of my body under the following conditions:

A. The photographs may be taken only with the consent of my physician and under such conditions and at such time as may be approved by him.

B. The photographs shall be taken by my physician or by a photographer approved by my physician.

C. The photographs shall be used for medical records and media purposes, and if it is in the judgment of Dr. Paciorek, medical research, education, or science will benefit from their use, such as photographs and information relating to my case may be published in professional journals, books, pamphlets, the office website, or any other purpose that he may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name.

Patient's name (PRINT): _____

Patient's signature: _____

Date: _____

If a minor or patient is unstable to affix signature: _____

Proxy/Guardian's name (PRINT): _____

Proxy/Guardian's signature: _____

Date: _____