# INFORMED CONSENT FOR SURGERY

1. I hereby request and authorize the surgeon aided by any assistants he/she may require, to perform in the presence of qualified medical personnel, the following procedures:

   _____

2. This surgery has been explained to me, and all of my questions about it have been answered, including a discussion of alternative methods of treatment, potential risks and complications, and the expected postoperative convalescence.

3. I know that the practice of medicine and surgery is not an exact science and that reputable physicians cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the operation, which I have herein requested and authorized.

4. I understand if the surgeon judges, at any time, that my surgery should be postponed or cancelled for any reasons, he may do so.

5. I also authorize the surgeon to perform any other procedures, which he may deem necessary or desirable regarding unforeseen conditions that he may encounter during the operation.

6. I understand that my surgery will involve incisions thru the skin, the nature of which have been explained to me and which may take a year or more to mature.

7. I consent to the administration of anesthetics to be given by, or under the direction of, the surgeon, and to use of such anesthetics and medications as he may deem advisable in my case.

8. I restate that the information furnished to the surgeon and staff on my medical history form and subsequent consultation is correct and complete. I understand that full knowledge of my current and past medical history is absolutely necessary for the surgeon and staff to plan my operation, anesthesia, and recovery. **I acknowledge that failure to disclose this information** will likely affect my final results.

9. I agree to follow the instructions given to me by the surgeon and staff to the best of my ability before, during, and after the above-named surgical procedure. I understand that post-operative follow-up is just as important to the final results as the surgery itself and that **I will keep all of my follow-up appointments.**

Signature _____ Signature _____

Patient/Guardian Witness

Date _____ Time _____

**PRE-ANESTHESIA HEALTH HISTROY**
Please Complete This Page

| NAME | HEIGHT | WEIGHT | BMI | OCCUPATION | AGE |
|---|---|---|---|---|---|
| | | | | | |

Pre-Op Vitals: BP_____ P _____ R _____ T_____ $O_2$ Sat _____ Glucose _____

YES NO

☐ ☐ Are you **ALLERGIC** to anything? Name medications and type of reactions (include latex rubber products, sulfites and food preservatives.)_____

_____

☐ ☐ Are you taking any **MEDICATIONS?** (Include prescription, over the counter, eye drops, inhalers and herbal medications).

Please list **ALL** medicine you are taking at home including prescriptions, over-the-counter, samples, supplements and herbals on the Green Sheet (Medication Reconciliation List)

**NOTE: IF YOU HAVE BEEN TAKING ANY ILLICIT (STREET) DRUGS, PLEASE TELL THE ANESTHESIOLOGIST. THIS IS IMPORTANT FOR YOUR SAFTERY.**

☐ ☐ Have you had previous **SURGERIES?** What anesthetics (local, block, spinal, epidural, general, awake or asleep)?

| SURGERY | YEAR | ANESTHESIA |
|---|---|---|
| | | |
| | | |
| | | |

☐ ☐ Can you climb a flight of stairs? 0 _____ 1_____ 2 _____ 3_____ or more _____
☐ ☐ Have you ever had problems with anesthetics (nausea, vomiting, malignant hyperthermia)? _____
☐ ☐ Has anyone in your family had unusual reactions to anesthetics? _____
☐ ☐ Have you / your friends / family (circle one) donated blood for your surgery? How many units? _____

YES NO **PLEASE CIRCLE THOSE THAT PERTAIN TO YOU:**

☐ ☐ Irregular Heart Beat / Heart Disease / Heart Valve Disease / Mitral Valve Prolapse_____
☐ ☐ Heart Attack / Angina / Chest Pain / Fainting _____
☐ ☐ High Blood Pressure _____
☐ ☐ Do you Have a Cold / Cough / Asthma (Wheezing)? _____
☐ ☐ Lung Disease / Difficult Breathing / Sleep Apnea _____
☐ ☐ Tobacco, How Much, How Long? Quit? _____
☐ ☐ Frequent Headaches / Stroke / Neurologic Disease _____
☐ ☐ Nervous Disorder / Seizures _____
☐ ☐ Diabetes / Thyroid Disease _____
☐ ☐ Kidney Disease / Liver Disease _____
☐ ☐ Infectious Disease (Hepatitis, HIV, TB, ect.)_____
☐ ☐ Heartburn, Gastritis, Esophageal Reflux, Hiatal Hernia, Ulcer_____
☐ ☐ Drink Alcoholic Beverages, How Much? _____
☐ ☐ Drug Use? _____
☐ ☐ Arthritis / Rheumatism, Where? _____
☐ ☐ Difficulty Opening Mouth or Moving Neck_____

**PRE-ANESTHESIA HEALTH HISTROY**
Please Complete This Page

| YES | NO | **PLEASE CIRCLE THOSE THAT PERTAIN TO YOU:** |
|---|---|---|
| ☐ | ☐ | Dentures, Chipped Loose Teeth, Special Dental Work |
| ☐ | ☐ | Bleeding / Blood Transfusion / Bruising / Sickle Cell / Clothing Problems _____ |
| ☐ | ☐ | Contact Lenses / Glaucoma _____ |
| ☐ | ☐ | If You Are Not Here Related To A Pregnancy, Are You Possibly **Pregnant**? _____ |
| ☐ | ☐ | Are You Currently Breast Feeding? _____ |

**IS THERE ANYTHING ELSE WE SHOULD KNOW?** _____

**ACKNOWLEDGEMENT OF RISKS AND CONSENT FOR ANESTHESIA**

Modern anesthesia is safe and usually well tolerated. However, even in experienced and competent hands, complications can occur. Minor problems include nausea and vomiting headache, injury to vocal cords, and injury to teeth, particularly dental work. Serious complications include unintended intraoperative awareness, nerve injury, and blindness, damage to one or more of the vital organs, even major disability or death. Other complications can occur. Although major complications of anesthesia are fortunately rare in healthy people, some types of health problems increase the risk of such occurrences. Therefore, it is important that you fully and accurately complete the health history questionnaire.

Prior to surgery, an anesthesiologist will talk with you. During this preoperative visit, you are encouraged to discuss to your satisfaction the recommended anesthesia, the possible alternative as well as a more detailed discussion of the risks of anesthesia mentioned above. Please ask as many questions as you feel necessary in order to assist you in making an informed decision.

Your signature on this page indicated your acknowledgement that risk of complication always exists as a result of anesthetic management.

Date: _____ Time: _____ ☐ A.M. ☐ P.M.

Signature: _____
Patient / Legal Representative

Patient physically unable to sign, reason: _____

Interpreter: _____ AM / PM
ID Code or Signature / Printed Name Date / Time

# Patient Disclosure Notice

Patient Rights & Responsibilities were established with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, family, physician and facility providing services. Patients shall have the following rights and responsibilities without regard to age, race gender, sexual orientation, national origin, cultural, economic, educational or religious background, physical handicap, personal values, belief systems or the source of payment for care.

**THE PATIENT HAS THE RIGHT TO:**

Receive the care necessary to help regain or maintain his or her maximum state of health and, if necessary, cope with an adverse outcome.

Expect personnel who care for the patient to be friendly, considerate, and respectful and qualified through education and experience to perform the services for which they are responsible with the highest quality of service. The patient has the right to be advised as to the credentials of healthcare professionals and the reason for the presence of any individual.

Expect full recognition of individuality, including personal dignity and privacy in treatment and care. In addition, all communications will be handled with discretion and confidentially kept.

Complete information, to the extent known by the physician, regarding diagnosis, evaluation, treatment and prognosis, as well as alternative treatments or procedures and the possible risks and side effects associated with treatment. The patient has the right to be informed by the physician or designee of continuing healthcare requirements, including reasonable provisions for the time and location of next appointments. When it is medically inadvisable to give such information to the patient, it will be provided to the patients designated or legally authorized representative.

Be fully informed of the scope of services available at the facility, provisions for after-hours and emergency care and payment policies.

Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's rights shall be exercised by the patient's designated representative or other legally designated person.

Make informed decisions regarding his or her care, except when such participation is contraindicated for medical reasons.
Refuse treatment to the extent permitted by the law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions should he or she refuse treatment or not follow the instructions of the physician or facility.

Approve or refuse the release of medical records to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third-party payment contract.

Be informed of any human experimentation or other research/educational projects affecting his or her care or treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.

Express grievances/complaints or suggestions at any time, verbally or in writing.

Change primary or specialty physicians or dentist if other qualified physicians or dentists are available.

Provide patient access to and/or copies of his or her individual medical records or billing information regardless of the source of payment.

Be informed as to the facility's policy regarding advance directives/living wills.

Be fully informed before any transfer to another facility or organization, except when an emergency situation prevents it.

Express those spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of medical therapy for the patient.

Have an initial assessment and regular reassessment of pain.

Receive educational information and instruction for patient and families, when appropriate, regarding their roles in managing pain, as well as potential limitations and side effects of pain treatment while considering personal, cultural, spiritual and/or ethnic beliefs in communicating to them and their families that pain management is an important part of care.

**THE PATIENT IS RESPONSIBLE FOR:**

Being considerate of other patients, providers and personnel, following facility rules, such as a no smoking policy, and for assisting in the control of noise and other distractions.

Respecting the property of others and the facility.

Reporting whether he or she clearly understands the planned course of treatment, what is expected of him or her and the presence of any directives that could affect care.

*(continued)*

Keeping appointments and providing a responsible adult to transport and give aftercare, as required by the provider, and, when unable to do so for any reason, notifying the facility and physician.

Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, including over-the counter products and dietary supplements, any known allergies or sensitivities, unexpected changes in the patient's condition or any other patient health matters.

Observing rules of the facility during his or her stay and following the treatment plan prescribed by the providers and, if such directions are not followed, forfeiting the right to care at the facility and being responsible for the outcome.

Accepting and promptly fulfilling his or her financial obligations to the facility.

**PATIENT CONCERNS AND/OR GRIEVANCES:**

Persons who have a concern or grievance regarding La Mesa Surgical Center's decisions regarding admission, treatment, discharge, denial of services, quality of services, courtesy of personnel or any other issue are encouraged to contact the Administrator in person, by phone (619-464-9876) or in writing to:

Administrator
La Mesa Surgical Center
8401 Grant Street
La Mesa, CA 91941

La Mesa Surgical Center is Medicare certified. Any complaints regarding services provided at the facility can be directed in writing or by phone to:

Department of Public Health
San Diego District Manager
7575 Metropolitan Drive, Suite 211
San Diego, CA 92108
(619) 688-6190

OR

Medicare patients may visit the following website to understand their rights and protections:

*www.cms.bhs.gov/center/ombudsman.asp*

**NOTICE TO CONSUMERS**

Medical doctors working at this facility are licensed and regulated by the Medical Board of California at (800) 633-2322,

*www.mbc.ca.gov*

**PHYSICIAN OWNERSHIP**

La Mesa Surgical Center is owned and operated by a surgeon. Your doctor may have an ownership interest in this facility. If this is a concern to you, please discuss it with your surgeon and be aware that you have the option to schedule your procedure at another facility.

**ADVANCED DIRECTIVES**

An "Advanced Directive" is a general term that refers to your oral and written instructions about your future medical care, in the event that you become unable to speak for yourself. Each state regulates the use of advanced directives differently. There are two types of advanced directives: a living will and a medical power of attorney. If you would like a copy of the official State advanced directive forms you may download them from: *www.calhealth.org*

**THIS CENTERS ADVANCE DIRECTIVE POLICY**

Although the elective, outpatient procedures performed at the Surgery Center are considered to be of minimal risk, no surgery is without risk. You and your surgeon will have discussed the specifics of your procedure and the risks associated with it, the expected recovery and the care after your surgery. It is the policy of this Surgery Center, regardless of the contents of any advance directive or instructions from a healthcare surrogate or attorney in fact, that if an adverse event occurs during your treatment here, the personnel at the Surgery Center will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. The center will only take a copy of your Advanced Directive for your chart in order to send it along with you to an acute care hospital for further treatment or withdrawal of treatment measures already begun in accordance with your wishes, advanced directive or health care power of attorney.

My signature below indicates I understand the Center will NOT honor a "Do Not Resuscitate" directive and I wish to proceed with surgery.
***I received the above information on patient rights, patient responsibilities advanced directive policy, physician disclosure and grievance policy in advance of my surgery.***

**Advance Directive Yes _____ No _____**

_____
**Print Name**

_____
**Signature**

_____
**Date**

_____
**Witness**

La Mesa Surgical Center
8401 Grant Ave, La Mesa Ca 91941

# Are You at Risk for a DVT Blood Clot?

Find out if you or a loved one is at risk for a Deep Vein Thrombosis (DVT) – a condition in which a blood clot can form in the deep veins of your legs.

1. Complete this form to help evaluate if you or a loved one is at risk for a DVT. Only a doctor can decide if you or a loved one are at risk for a DVT blood clots* Check all statements that apply
2. Add up the numbers of points shown for each of the checked statements to get the DVT risk factor score.

3. Share your completed form with your doctor or loved one's doctor.

Name: _____

**What does a DVT risk factor score mean?**

Low risk (0-1 point) - you may not be at risk now, but it's a good idea to reassess your risk of DVT at regularly scheduled doctor visits or annual exams.

Moderate risk (2 points) – share your answers to this survey with your doctor at your next scheduled appointment so he or she can assess your risk of DVT.

High risk (3+ point) – because of your increased risk you would share your answers with your doctor so that he or she can assess your risk of DVT.

Date: _____

**Add 5 points for each of the following statements that apply:**

- ☐ **Recent elective hip or knee joint replacement surgery**
- ☐ **Broken hip, pelvis, or leg within the last month**
- ☐ **Serious trauma within the last month (for example, a fall, broken bone, or car accident)**
- ☐ **Spinal cord injury resulting in paralysis within the last month**

**Add 3 points for each of the following statements that apply:**

- ☐ **Age 75 or over**
- ☐ **History of blood clots, either Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE)**
- ☐ **Family history of blood clots (thrombosis)†**
- ☐ **Family history of blood-clotting disorders**

**Add 2 points for each of the following statements that apply:**

- ☐ **Age 60-74**
- ☐ **Cancer (current or previous)**
- ☐ **Recently had major surgery that lasted longer than 45 minutes**
- ☐ **Recent laparoscopic surgery that lasted longer than 45 minutes (surgery performed through a small incision with a lighted tube shaped instrument)**
- ☐ **Recently confined to bed rest for more than 72 hours**
- ☐ **Plaster cast that has kept you from moving your limb within the last month**
- ☐ **Tube in blood vessel in neck or chest that delivers blood or medicine directly to heart (also called central venous access)**

**For women only: Add 1 point for each of the following statements that apply:**

- ☐ **Use birth control or hormone replacement therapy (HRT)**
- ☐ **Pregnant or had a baby within the last month**

**Add 1 point 1 for each of the following statements that apply:**

- ☐ **Age 41-60 years**
- ☐ **Planning minor surgery in the near future**
- ☐ **Had major surgery within the last month**
- ☐ **Varicose veins**
- ☐ **A history of inflammatory Bowel Disease (IBD) (for example, Crohn's disease or ulcerative colitis)**
- ☐ **Legs are currently swollen**
- ☐ **Overweight or obese**
- ☐ **Heart attack**
- ☐ **Congestive heart failure**
- ☐ **Serious infection (for example, pneumonia)**
- ☐ **Lung disease (for example, emphysema or COPD)**
- ☐ **Currently on bed rest or severely restricted mobility**

## Total Risk Factor Score _____

*this is a partial list of risks factors. Ask your doctor about the other risk factors or conditions that may predispose you to DVT blood clots.

† most frequently missed risk factor

# Health Disclosure Statement

ALLERGIES AND SENSITIVITIES

Is there any history of skin reactions or other illness following contact with:

□ yes □ no Penicillin, Sulfa or other antibiotic?
□ yes □ no Morphine, Codeine, Demerol or narcotic?
□ yes □ no Novocain, Lidocaine or local anesthetics?
□ yes □ no Tetanus toxoid or serums?
□ yes □ no Adhesive tape?
□ yes □ no Iodine, Betadine, Chlorhexidine or Phisohex?
□ yes □ no Latex rubber?
□ yes □ no **Other drug, medicines, or substance allergies or sensitivities?**
(If yes list her and note adverse reaction)

LATEX ALLERGY AND SENSITIVITY SCREENING

□ yes □ no Seasonal hay fever?
□ yes □ no Asthma?
□ yes □ no Eczema?
□ yes □ no Autoimmune disease?
□ yes □ no On the job exposure to latex?
□ yes □ no Myelomeningocele, spina bifida, spinal cord Defect or congenial urinary tract problems?
□ yes □ no Catheterize to urinate?
□ yes □ no Allergic to bananas, kiwi fruit, or chestnuts?
□ yes □ no Allergic to avocados and / or guacamole?
□ yes □ no Allergic reaction blowing up balloons?
□ yes □ no Allergic reaction during dental exams?
□ yes □ no Allergic reaction to condoms or diaphragms?
□ yes □ no Allergic reaction with vaginal or rectal exam?
□ yes □ no Anaphylaxis or severe allergy attack?

ANESTHESIA

□ yes □ no Adverse or unusual reaction to anesthesia?
□ yes □ no Nausea and / or vomiting after anesthesia?

SURGERY

□ yes □ no Abnormal healing or poor scar formation?
□ yes □ no Adverse or unusual reaction to surgery?
□ yes □ no Do you have a blood relative who had anesthesia complication of any kind?
(If yes list her and note adverse reaction)

DRUGS AND MEDICINES

Have you, within the last 6months, taken any of the following:

□ yes □ no Cortisone, Prednisone or ACTH?
□ yes □ no Diuretics or water pills?
□ yes □ no Blood pressure medication?
□ yes □ no Steroids or body building drugs?
□ yes □ no Seizure medication?
□ yes □ no Insulin or diabetes medication?
□ yes □ no Asthma medication?
□ yes □ no Heart medication?
□ yes □ no Anticoagulants or blood thinners?
□ yes □ no Pain pills?
□ yes □ no Appetite suppressants or diet pills?
□ yes □ no "Fen/Phen", Redux, Pondimin, Phentermine or fenfluramine?
□ yes □ no Sedatives, tranquilizers or sleeping pills?
□ yes □ no Antidepressants, anti-anxiety, anti-psychotics or nerve pills
□ yes □ no Antabuse?
□ yes □ no Methadone?
□ yes □ no Recreational or illegal drugs?

MEDICATIONS THAT CAUSE BLEEDING

Do you take any of the following on a regular basis:

□ yes □ no Aspirin or aspirin containing medications?
□ yes □ no Ibuprofen (Motrin, Advil, Nuprin) ?
□ yes □ no Naproxen (Aleve, Anaprox, Naprosyn)?
□ yes □ no Ketoprofen (Orudis, Oruvail)?
□ yes □ no Vitamin E? (Other than in a multivitamin)
□ yes □ no NSAIDs (non-steroidal anti-inflammatories)?

IMPORTANT MEDICAL CONDITIONS

Have you ever had or received treatment for any of the following:

General

□ yes □ no Recent weight gain or loss?
□ yes □ no Organ transplant

Hepatic

□ yes □ no Hepatitis, jaundice, cirrhosis or liver disease?

Pulmonary

□ yes □ no Asthma, TB, emphysema or chest disease?
□ yes □ no Pneumonia?
□ yes □ no Pulmonary embolus?
□ yes □ no Sleep Disorder?
□ yes □ no Severe snoring or sleep apnea?

# La Mesa Surgical Center

8401 Grant Ave, La Mesa Ca 91941

Cardiovascular

| | | |
|---|---|---|
| □ yes | □ no | High blood pressure? |
| □ yes | □ no | Palpitations or irregular heartbeats? |
| □ yes | □ no | Mitral valve prolapse? |
| □ yes | □ no | Shortness of breath, dizziness or fainting? |
| □ yes | □ no | Ankle swelling? |
| □ yes | □ no | Chest pain or angina? |
| □ yes | □ no | Heart attack? |
| □ yes | □ no | Rheumatic fever or congenital heart disease? |
| □ yes | □ no | Pacemaker? |
| □ yes | □ no | Artificial heart valve? |
| □ yes | □ no | Heart surgery |
| □ yes | □ no | Cardiac stent? |

Hematologic

| | | |
|---|---|---|
| □ yes | □ no | Blood transfusion? |
| □ yes | □ no | Anemia or blood disorder? |
| □ yes | □ no | sickle cell disease or trait? |
| □ yes | □ no | Abnormal bleeding? |
| □ yes | □ no | Family history of abnormal bleeding? |
| □ yes | □ no | Frequent nosebleeds or heavy menstrual periods? |
| □ yes | □ no | Easy bruising? |
| □ yes | □ no | Bleeding or clotting problem during pregnancy? |
| □ yes | □ no | Von Willebrand's disease? |
| □ yes | □ no | Leiden Factor V Protein C resistance? |
| □ yes | □ no | Pulmonary embolism (PE) (blood clot in lungs)? |
| □ yes | □ no | Family history of DVT, PE or blood clot? |

Addiction / Substance Abuse

| | | |
|---|---|---|
| □ yes | □ no | History of alcohol abuse or alcoholism? |
| □ yes | □ no | History of drug abuse or addiction? |

Eye

| | | |
|---|---|---|
| □ yes | □ no | Glaucoma? |
| □ yes | □ no | Cataracts or cataract surgery? |
| □ yes | □ no | Lasik or laser vision correction? |
| □ yes | □ no | Use of eye drops or ointment? |
| □ yes | □ no | Dry eye problems? |
| □ yes | □ no | Eye glasses? |
| □ yes | □ no | Contact lenses? |

Joints

| | | |
|---|---|---|
| □ yes | □ no | Stiff neck? |
| □ yes | □ no | Gout? |
| □ yes | □ no | Back Problems? |
| □ yes | □ no | Artificial joint? |

Ears

| | | |
|---|---|---|
| □ yes | □ no | Decreased hearing or hearing loss? |
| □ yes | □ no | Ear tubes or perforated eardrum? |
| □ yes | □ no | History of inner ear surgery? |
| □ yes | □ no | Cochlear implant? |

Renal / Urinary

| | | |
|---|---|---|
| □ yes | □ no | Kidney failure, kidney or prostate problems? |
| □ yes | □ no | Urinary tract problems? |

Endocrine

| | | |
|---|---|---|
| □ yes | □ no | Diabetes? |
| □ yes | □ no | Thyroid problem or Graves' disease? |
| □ yes | □ no | Addison's disease / adrenal problem? |

Gastrointestinal

| | | |
|---|---|---|
| □ yes | □ no | Ulcer disease? |
| □ yes | □ no | Pancreatitis? |
| □ yes | □ no | Inflammatory bowel disease ("IBD") |
| □ yes | □ no | Gastro esophageal reflux? ("GERD") |
| □ yes | □ no | "Hiatal Hernia"? |

Neurovascular

| | | |
|---|---|---|
| □ yes | □ no | Migraines, headaches or chronic head pain? |
| □ yes | □ no | Seizures? |
| □ yes | □ no | Stroke? |
| □ yes | □ no | Bell's palsy or neurological problems? |
| □ yes | □ no | Nerve injury? |

Immunological

| | | |
|---|---|---|
| □ yes | □ no | Lupus, arthritis or auto immune disease |
| □ yes | □ no | Splenectomy (removal of spleen)? |
| □ yes | □ no | Chronic Fatigue syndrome> |
| □ yes | □ no | HIV or AIDS? |

Extremity

| | | |
|---|---|---|
| □ yes | □ no | Phlebitis, blood clots or varicose veins? |
| □ yes | □ no | Frostbite? |
| □ yes | □ no | Cold intolerance or Raynaud's Disease? |
| □ yes | □ no | Poor circulation, leg ulcers, or peripheral vascular disease |

Mental health

| | | |
|---|---|---|
| □ yes | □ no | Trouble making decisions for self? |
| □ yes | □ no | Psychological or emotional problems? |
| □ yes | □ no | Depression? |
| □ yes | □ no | Anxiety disorder? |
| □ yes | □ no | Claustrophobia or panic attacks? |
| □ yes | □ no | Nervous breakdown? |
| □ yes | □ no | Personality disorder? |
| □ yes | □ no | Bipolar or manic depressive illness? |
| □ yes | □ no | Schizophrenia? |
| □ yes | □ no | Eating disorder, anorexia or bulimia? |
| □ yes | □ no | Body Dysmorphic Disorder (BDD) |
| □ yes | □ no | Have you ever been sexually abused? |
| □ yes | □ no | Currently in therapy or counseling? |
| □ yes | □ no | Currently confused, depressed, or having suicidal thoughts? |

Oral

□ yes □ no Dentures
□ yes □ no Capped teeth, bridges or veneers?
□ yes □ no Loose teeth or gum disease?
□ yes □ no Cold sores, fever blisters or oral herpes?
□ yes □ no Other oral / dental problems?

Skin

□ yes □ no Rosacea?
□ yes □ no Rhingles or herpes zoster?
□ yes □ no History of taking Accutane?
□ yes □ no History of laser skin treatments?
□ yes □ no History of "skin shrinking" treatments?
□ yes □ no History of Thermage or radio frequency treatments?
□ yes □ no History of Ulthera, Ultherapy or ultrasonic skin treatments?
□ yes □ no History of cystic acne?
□ yes □ no Angioedema, persistent or unusual swelling?
□ yes □ no X-Ray treatments or radiation therapy?
□ yes □ no Using Juvaderm, Restylane, radiesse or fillers?
□ yes □ no Using Botox or Dysport?
□ yes □ no Silicone or permanent filler injections?
□ yes □ no History of MRS (drug resistant staph aureus)?

Hair

□ yes □ no Alopecia?
□ yes □ no Thinning Hair or hair loss?
□ yes □ no fragile hair?
□ yes □ no Hairpiece / Hair replacement system?
□ yes □ no Hair extensions?
□ yes □ no Hair implants?

Habits/ Lifestyle

□ yes □ no Exercise regularly?
□ yes □ no Healthy diet?
□ yes □ no Use sunscreens / avoid sun?
□ yes □ no Wear seat belts?
□ yes □ no Take Vitamins or other supplements?
□ yes □ no Regular physical exam?

PREGNANCY (WOMEN)

□ yes □ no Are you sexually active?
□ yes □ no Are you currently using birth control?
□ yes □ no Are you now pregnant or is there any possibility you might be?

Date of last menstrual period? _____

Social/ Family

□ yes □ no Is there violence in your home?
□ yes □ no Is anyone threatening you or making you feel bad about yourself?
□ yes □ no Are you, or have you been in a relationship in which you have been physically hurt or threatened by your spouse, partner, a family member or other person close to you?
□ yes □ no Is there someone close to you or are there members of your family who strongly object to you having plastic surgery?
□ yes □ no Do you know of any reason you should not undergo surgery and anesthesia?
□ yes □ no **Other Medical Conditions?**
(If yes list here)

SMOKING

□ yes □ no Do you currently smoke or have you smoked in the past? **If yes:**

Average number of packs smoked per day _____

Approximate number of total years smoking _____

If quit, number of years ago quit _____

**VITAMINS SUPPLEMENTS, AND HOMEOPATHIC AND HERBAL MEDICATIONS CURRENTLY TAKEN**

□ none □ yes (if yes please list all here)

**REVIOUS (NON-COSMETIC) SURGERY PROCEDURES**

□ none □ yes (if yes please list all here)

# La Mesa Surgical Center

8401 Grant Ave, La Mesa Ca 91941

**PREVIOUS COSMETIC SURGERY PROCEDURES**

- ☐ **NO** I have **not** had any previous cosmetic surgery procedures
- ☐ **Yes** I have undergone previous cosmetic surgery procedures as follows:

(If yes please list all previous procedures performed on face, breast or any other part of your body and approximate dates of each here)

**MEDICATIONS CURRENTLY TAKEN**

- ☐ **NO** I do **not** currently take medicines on a regular basis
- ☐ **Yes** I take medicines on a regular basis as follows:

(If yes please list all medicines taken here along with dose and times taken)

**DECLARATION**

I certify that the preceding is true, correct and complete. I am aware and accept that withholding information about my medical history could result in serious injury to me or harm to those involved in my care

Patient's signature _____ Date _____