



CONSULTATION AND MEDICAL QUESTIONNAIRE, PART I

DEMOGRAPHIC INFORMATION		
Today's Date:		
Name:		
Date of Birth:	Age:	
Email:		
Social Security #:		
Home Address:		
City	State	Zip
Home Phone #:		
Cell Phone #:		
Work Phone #:		
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		
Spouse Name:		
Spouse Phone #:		
Emergency Contact:		
Emergency Contact #:		
Occupation:		
Employer:		
Insurance Company:		
Phone #:		
Policy #:	Subscriber #:	

HOW DID YOU HEAR ABOUT DR. KAPOOR?		
(PLEASE CIRCLE ALL THAT APPLY)		
Friend	Patient	Family Member
If so, Name: _____		
May we thank them? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Google / Yahoo	1-800 My Surgeon	Paper / Ad
SmartPlasticSurgery.Com	LookingYourBest.Com	
Gynecomastia.org		
Other (Specify): _____		

WHICH PROCEDURES ARE YOU INTERESTED IN?
<input type="checkbox"/> BREAST ENHANCEMENT (Breast Augmentation, Breast Lift, or Breast Reduction)
<input type="checkbox"/> TUMMY TUCK / ABDOMINOPLASTY (Removal of excess skin and fat of the abdomen)
<input type="checkbox"/> LIPOSUCTION / LIPOSCULPTURE (Minimally invasive removal of localized fat deposits)
<input type="checkbox"/> MALE BREAST REDUCTION / GYNecomASTIA (Removal of excess fat and breast tissue from the chest)
<input type="checkbox"/> FACE LIFT / NECK LIFT / MIDFACE LIFT (Tightening of skin and muscles of the face and neck)
<input type="checkbox"/> EYELID LIFT (Removal of excess skin and fat from the eyes)
<input type="checkbox"/> EYEBROW / FOREHEAD LIFT (Lifting of the eyebrow through minimal incisions)
<input type="checkbox"/> RHINOPLASTY / SEPTOPLASTY (Reshaping and straightening of the nose to improve breathing)
<input type="checkbox"/> FACIAL IMPLANTS (Augmentation of the chin or cheek with implants)
<input type="checkbox"/> ARM LIFT (Removal of excess skin and fat of the arms)
<input type="checkbox"/> THIGH LIFT (Removal of excess skin and fat of the thighs)
<input type="checkbox"/> BUTTOCK AUGMENTATION (Enhancement of the buttocks with implants or fat)
<input type="checkbox"/> BOTOX® (To soften the wrinkles around the eyes and forehead)
<input type="checkbox"/> RESTYLANE® / JUVEDERM® / RADIESSE® (Fillers to improve the deeper wrinkles of the face)
<input type="checkbox"/> PHOTOFACIAL (A laser treatment to improve redness and pigmentation of the face)
<input type="checkbox"/> LASER HAIR REMOVAL (A laser treatment to reduce or eliminate unwanted hair)
<input type="checkbox"/> LASER RESURFACING / CHEMICAL PEEL (A laser treatment to smooth out facial wrinkles and acne scarring)
<input type="checkbox"/> OBAGI SKIN CARE / NIA SKIN CARE (A skin care system to help blemishes, acne, and large pores)
<input type="checkbox"/> SCAR REVISION (Surgical improvement of unsightly appearing scars)
<input type="checkbox"/> OTHER (Please specify): _____
WHEN DO YOU WISH TO HAVE YOUR PROCEDURE?
<input type="checkbox"/> ASAP <input type="checkbox"/> Within 1 month <input type="checkbox"/> 1-3 months <input type="checkbox"/> Not Sure

AUTHORIZATION / ASSIGNMENT: I understand that I am financially responsible for all charges, whether or not covered by my insurance company. Furthermore, I permit payment directly to VISHAL KAPOOR, MD, INC. for any benefits due or services rendered.
MEDICAL RECORDS: Authorization is hereby granted for release of any information required to process this claim. A copy of this authorization is as valid as the original. Authorization is hereby granted for release of pertinent information (this may include photographs, operative notes, clinic and consultation notes) to a hospital / another physician's office for appropriate continuum of care treatment as required.
PRIVACY POLICY: I acknowledge I have received / have been offered a copy of VISHAL KAPOOR, MD, INC.'s notice of privacy practices.
Signature: _____
Date: _____



CONSULTATION AND MEDICAL QUESTIONNAIRE, PART II

MEDICAL HISTORY	
Height:	Weight:
Family Physician:	
Address / Phone Number:	

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

(PLEASE CIRCLE ALL THAT APPLY)

Headaches	Strokes
Seizures	Fainting Spells
Heart Disease	High Blood Pressure
Chest Pain	Shortness of Breath
Lung Disease	Thyroid Disease
Liver Disease / Hepatitis	Ulcers
Anemia	Bleeding Problems
HIV	Blood Clots
Family / Personal history of problems with Anesthesia	

Do you have any other medical problems / conditions? (Please list below)

Have you ever had surgery before? (Please list below)

Type	Date

List any medications you take on a regular basis (Including appetite suppressants, vitamins, herbal supplements, or any homeopathic medication)

Name	Dosage

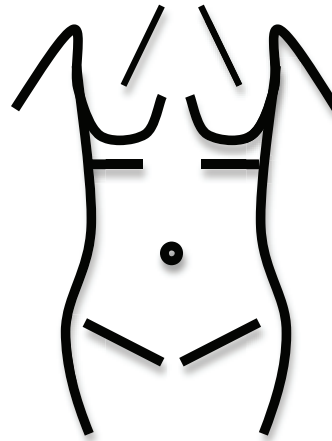
Do you have any allergies to medications?

Name	Reaction

SOCIAL HABITS	
Cigarette Smoking:	<input type="checkbox"/> Yes <input type="checkbox"/> No # of cigarettes / day: ____
Alcohol Use:	<input type="checkbox"/> Yes <input type="checkbox"/> No # drinks / week: ____
Drug Use:	<input type="checkbox"/> Yes <input type="checkbox"/> No

FOR WOMEN ONLY	
# of pregnancies:	# of live births:
Did you breast feed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any family / personal history of breast cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of last mammogram:	Results:

DOCTOR'S NOTES



Surgical Procedure(s) / Plan	Time (hrs)
1.	
2.	
3.	
4.	