MEDICAL HISTORY

Name:

Internist/Family Physician/General Practitioner:_____

Injuries:

Year_____Type_____
_____
_____

Previous Surgeries:

Year	Operation	Doctor	Hospital	Complications?

Have you ever had a bad reaction to general anesthetic?	No_____Yes_____
Has anyone in your family ever had a bad reaction to anesthesia?	No_____Yes_____
Have you ever had a bad reaction to local anesthetic?	No_____Yes_____
Have you had a tubal ligation or a hysterectomy?	No_____Yes_____
Are you allergic to tape?	No_____Yes_____
Are you allergic to latex?	No_____Yes_____
Do you have high blood pressure?	No_____Yes_____
Have you ever had scarlet or rheumatic fever?	No_____Yes_____
Do you bleed unusually easily?	No_____Yes_____
Do you have diabetes?	No_____Yes_____
Are you a slow or poor healer?	No_____Yes_____
Do you form large scars or keloids?	No_____Yes_____
Do you have any skin disease or rash?	No_____Yes_____
Do you have frequent infections or boils?	No_____Yes_____
Have you taken steroid medication, cortisone or ACTH?	No_____Yes_____
Do you have shortness of breath with walking?	No_____Yes_____
Have you ever had significant emotional problems?	No_____Yes_____
Have you ever been advised to see a psychiatrist?	No_____Yes_____
Have you ever been diagnosed with tuberculosis?	No_____Yes_____
Have you ever been diagnosed with hepatitis?	No_____Yes_____
Have you ever had psychiatric care?	No_____Yes_____

If yes, please explain: _____

(Women) Do you experience prolonged or heavy periods? No_____Yes_____

CIRCLE if you have had problems in any of the following areas?

BRAIN	NOSE	CHEST	STOMACH	ARMS	EYES	HEART
THROAT	LUNGS	INTESTINES	LEGS	EARS	NECK	KIDNEY

Explain: _____

Are you allergic to any drugs or medications? No_____ Yes_____

If yes, which ones: _____

MEDICAL HISTORY

Please list ALL medications you are currently taking or have been prescribed by a physician in the past 6 months?
list:_____

MEDICATIONS

I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills). And I may be asked to refrain from other medications depending on the type of procedure selected.

(Initials_____)

SMOKING

Do you smoke?_____How much?_____
I understand this may cause a delay in my healing process. I also understand that it is highly recommended by Dr. Ayala that I refrain from doing so at least three weeks before any treatment is preformed.

(Initials_____)

EXAMINATION

I understand that plastic surgery is not an exact science and that therefore reputable practitioners can not guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding treatment I have requested and authorized. I also understand that not every individual is a candidate for surgery and the initial consultation is not to be considered as such. The final decision will be made by the physician upon completion of my evaluation.

(Initials_____)

TREATMENT

I am electing to have surgery/treatment for the following reasons. Please explain in detail:
_____
I understand that my initial visit may require photos in order to complete the examination, diagnosis and treatment plan. At which time, my pre and post operative photos will be available for other potential patients to view, either displayed in the office or on our web site.

(Initials_____)

Have you ever been dissatisfied with any previous surgery(ies) in the past? YES / NO

If yes, please explain: _____

Are you currently involved in any legal action (lawsuit) or have you ever considered legal action in the past? YES / NO
If yes, please explain: _____

On a scale from 1 thru 10, (1 being the least and 10 being the greatest) how would you describe your level of satisfaction with your over all appearance at this time? 1 2 3 4 5 6 7 8 9 10

Using the same scale graph, how would you describe your level of expectation with your over all appearance to be? 1 2 3 4 5 6 7 8 9 10

Signature _____ Date _____

PHOTO CONSENT

Instructions

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides, and or videotapes and to use these images for a purpose as defined within this consent documentation.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as purposed by your plastic surgeon.

Introduction

Medical photographs/slides and videotapes may be taken before, during, or after a surgical proce dure or treatment. Consent is required to take such images.

Additionally, patients may consent to release these medical photographs/slides and videotapes for a stated purpose.

1. **Consent to take photographs/slides/videotapes**

   I hereby authorize John Ayala, M.D. and/or his associates or licensees to use pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes. I additionally consent to photographs, slides and/or videotapes of my interview.

2. **Consent for release of photographs/ slides/videotapes**

   I hereby authorize John Ayala, M.D. and/or his associates or licensees to use pre-operative, intra-operative, and post-operative photographs, slides, and or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay education, or during lectures to medical or lay groups.

   I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and or my interview.

Date: _____

Patient Signature: _____

Witness; _____