DR. CONNIE HIERS
Plastic Surgery & Med Spa

Patient History Questionnaire

NAME:_____ AGE:_____ BIRTH/DATE:_____

SEX (Male / Female / Other) HEIGHT:_____ WEIGHT:_____ SSN: _____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

E-MAIL ADDRESS:_____ (Great way to receive our coupons and specials.)

HOME PHONE: _____WORK PHONE:_____CELL PHONE: _____

* Please circle the best way to contact you on the options above_____

PERSONAL PHYSICIAN:_____

HOW DID YOU HEAR ABOUT US? ☐Internet ☐Radio ☐T.V. ☐AD ☐ Friend or Family ☐ Event ☐ Drive by

PERSON WHO REFERRED YOU:_____

EMERGENCY CONTACT PERSON_____ PHONE #:_____

REASON FOR TODAY'S VISIT _____

PARTS OF BODY TO BE TREATED _____

PATIENT MEDICAL HISTORY : ANSWER YES OR NO TO THE FOLLOWING. IF ANSWERED YES, PLEASE CIRCLE AND EXPLAIN UNDER COMMENTS.

NO	**YES**	
___	___	PREVIOUS LIPOSUCTION / FACE LIFT / OTHER COSMETIC SURGERIES
___	___	CONSTITUTIONAL (Fever, weight loss, night sweats)
___	___	CARDIOVASCULAR (Heart attack, stroke, chest pain, valve disease)
___	___	RESPIRATORY (Emphysema, asthma, tuberculosis)
___	___	ENDOCRINE (Diabetes, thyroid)
___	___	VIRAL (Herpes, HIV)
___	___	MUSCULOSKELETAL (Previous fracture, muscle or bone disease, arthritis)
___	___	INTEGUMENTARY (Psoriasis, eczema)
___	___	PSYCHIATRIC (Depression, anxiety)
___	___	HEMATOLOGIC (Anemia, bleeding tendency)
___	___	GENITAL/URINARY (Infection, kidney stones, prostate)
___	___	GASTROINTESTINAL (Ulcer, gastritis, colitis)
___	___	EYES (Glaucoma, cataract)
___	___	EARS/NOSE/MOUTH/THROAT
___	___	NEUROLOGICAL (Seizures, numbness, tremors)
___	___	OTHER PROBLEMS (High cholesterol or blood pressure, cancer)

COMMENTS:_____

_____

_____

_____

PAST MEDICAL HISTORY:

Previous operations – cosmetic or health related:

_____

_____

Issues with Anesthesia? Y/N If yes, please explain: _____

_____

Allergies to medications:

_____

Current medications, vitamins and supplements and their dosage:

1)_____ 4)_____

2)_____ 5)_____

3)_____ 6)_____

FAMILY HISTORY:

Has anyone in your family had any of the following illnesses? If yes, please identify the family member.

YES	NO		If yes, circle?		
___	___	Lung disease/asthma/emphysema	Mother / Father	Sister / Brother	Grandparent
___	___	Heart disease, heart attack	Mother / Father	Sister / Brother	Grandparent
___	___	High blood pressure	Mother / Father	Sister / Brother	Grandparent
___	___	Diabetes	Mother / Father	Sister / Brother	Grandparent
___	___	Cancer	Mother / Father	Sister / Brother	Grandparent
___	___	Arthritis	Mother / Father	Sister / Brother	Grandparent

Other_____

SOCIAL HISTORY:

Marital status ___S___M___W___D If married, spouse's name: _____Contact #_____

How many children? _____ Ages? _____ Miscarriages? _____

Is there any possibility that you may be pregnant at this time? YES _____ NO ___

Current employer:_____

Job description:_____

Do you smoke cigarettes? ____ If yes, how many packs per day?____ How long?_____

Do you drink alcohol? ___ If yes, how many days per week? _____Drinks per day?_____

Do you have a current or past history of substance abuse?_____

If yes, please explain_____

Patient/Legal Guardian Signature:_____ **Date:**_____

Physician Signature:_____ **Date**:_____

NO SHOW POLICY:

Your appointment time has been specially reserved for you, should you be unable to keep your appointment a minimum of 24 hours' notice is appreciated. Failure to give adequate notice may result in a minimum charge of $75 and / or full prepayment of your next booking which will be non-refundable. If a treatment package appointment is missed without 24 hours' notice, you will forfeit that day's treatment. We will hold a credit card on file for your convenience and to secure appointments. It is kept in a password protected location.

Please Read & Initial: _____

FINANCIAL POLICIES

A member of our team will meet with you after your consultation and discuss fees and procedures for scheduling surgery. The fees will include the *estimated* surgery and anesthesia fees, routine lab tests, and operating room costs. **Additional fees for radiology, pathology, or other lab testing may not be known.**

Payment for cosmetic surgery is due in full at the time of your pre-operative visit or no later than 2 weeks prior to your surgery date. Several payment options are available: cash, personal or cashier's check, credit card, and interest free financing through Care Credit (www.carecredit.com) and Alphaeon Credit (www.goalphaeon.com) Personal checks cannot be accepted within 2 weeks from your surgery.

All surgical procedures require a booking fee of **$500**. This will hold your pricing and surgical date for up to two months. The fee will be applied to the total cost of your surgery. It can be refunded for cancellations up to 48 Hours prior to your surgery date. Less than 72 hours notice $500 will be forfeited to cover costs of the cancellation. _____ initial

Credit Policy

A Credit on file on file for Botox and Fillers or surgery must be used within 3 months of issuance. If not used, you will forfeit this credit. Credit for Med Spa must be used within 2 months. Credit can be used toward Surgery, Med Spa services, Med Spa Products (up to $200) Injections and Gift Cards. NO credit will be carried over to the New Year. _____ initial

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Date

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Date