PATIENT INFORMATION FORM

Patient Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Gender: _____

Social Security Number: _____ Marital Status: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

Who referred you (how did you hear about Dr. Stiller)? _____

What is the nature of your visit? _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Financial Policy

In order for Stiller Aesthetics to continue providing our patients with quality medical care, we must receive the contracted payment for our services. Ensuring that we are appropriately paid is our PATIENT'S RESPONSIBILITY. As a patient of Stiller Aesthetics you are hereby agreeing to pay all charges, at the time of services or when otherwise informed. Further, you agree that Stiller Aesthetics has the right to be paid for their services. You acknowledge that unpaid bills older than 90 days from the date of service may be turned over to a debt collection agency or attorney for collection. You will be responsible for any resulting collection fees, including reasonable attorney fees, and/or bank fees incurred as a result of a returned check.

I have read and understand the above financial policy of Stiller Aesthetics.

_____ _____

Patient or Guarantor Signature Date

Procedures or Products of Interest

Body:

- ☐ Liposuction / Lipocontouring
- ☐ Body contouring after major weight loss
- ☐ Tummy tuck
- ☐ Buttock lift
- ☐ Thigh lift
- ☐ Buttock enlargement (Brazilian Butt Lift)
- ☐ Correction of tummy tuck or liposuction
- ☐ Arm lift
- ☐ Body lift
- ☐ Hernia repair
- ☐ Labia repair
- ☐ Other:

Breast:

- ☐ Breast enlargement
- ☐ Breast implant revision
- ☐ Breast reduction
- ☐ Breast lift
- ☐ Breast lift with enlargement
- ☐ Nipple reduction
- ☐ Correction of inverted nipples
- ☐ Male chest reduction

Face:

- ☐ Nose surgery
- ☐ Breathing problems
- ☐ Eyelid lift
- ☐ Brow lift
- ☐ Face lift
- ☐ Ear pinning
- ☐ Neck lift or liposuction
- ☐ Chin enlargement
- ☐ Buccal fat removal

In Office:

- ☐ Botox
- ☐ Juvederm
- ☐ Latisse
- ☐ Skin care
- ☐ Scar revision
- ☐ Mole removal

Section I: Surgery and Anesthesia History

1. Have you ever had surgery? ☐ No ☐ Yes, please describe:

_____

_____

_____

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

_____

_____

Section II: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes Height: _____ Weight: _____

Have you or do you still have:	No	Yes	Description
2. Asthma	☐	☐	
3. Emphysema	☐	☐	
4. High Blood Pressure	☐	☐	
5. Heart Trouble	☐	☐	
6. Hepatitis or Liver Trouble	☐	☐	
7. Kidney Trouble	☐	☐	
8. Diabetes	☐	☐	
9. Epilepsy or Seizures	☐	☐	
10. Stroke	☐	☐	
11. Problem Scarring	☐	☐	

12. Have you been advised to or had psychiatric care? ☐ ☐ _____

13. Others Not Listed: _____

Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? _____
2. Do you drink? ☐ No ☐ Yes, how much? _____
3. Do you have children? ☐ No ☐ Yes, how many? _____

Section IV: Family History

	Have any blood relatives had any of the following?	No	Yes	Description
1.	Cancer	☐	☐	
2.	Bleeding Tendency	☐	☐	
3.	Leukemia	☐	☐	
4.	Heart Disease	☐	☐	
5.	High Blood Pressure	☐	☐	
6.	Repeated Infections	☐	☐	
7.	Chronic Lung Disease	☐	☐	
8.	Tuberculosis	☐	☐	
9.	Asthma	☐	☐	
10.	Severe Allergies	☐	☐	
11.	Kidney Disease	☐	☐	
12.	Crippling Arthritis	☐	☐	
13.	Mental Illness	☐	☐	
14.	Convulsions or Fits	☐	☐	
15.	Migraine Headaches	☐	☐	
16.	Diabetes	☐	☐	
17.	Gout	☐	☐	
18.	Thyroid Trouble	☐	☐	
19.	Obesity	☐	☐	

		Present Age or Age at Death	If Living, Health (good, fair, poor)	If Deceased, Cause of Death
1.	Father:			
2.	Mother:			
3.	Brothers/Sisters:			

Section V: Medications

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

_____

_____

	Are you taking or have you taken in the past:	No	Yes	Description
1.	Medication for blood pressure or water pills?	☐	☐	
2.	Antidepressants, tranquilizers or sedatives?	☐	☐	
3.	Blood thinners including Motrin, Advil or Aspirin?	☐	☐	
4.	Steroids?	☐	☐	
5.	Diabetic Medication?	☐	☐	
6.	Seizures	☐	☐	
7.	Heart Medications?	☐	☐	
8.	Other Medications:			

	Medications that cause bleeding: Do you take any of the following on a regular basis:	No	Yes	Description
1.	Aspirin or aspirin containing medications?	☐	☐	
2.	Ibuprofen (Motrin, Advil & Nurpin)?	☐	☐	
3.	Ketoprofen (Alleve)?	☐	☐	
4.	Vitamin E (excluding that in a multivitamin)?	☐	☐	
5.	Anti-inflammatories or muscle relaxants?	☐	☐	

Section VI: Allergies and Sensitivities

	Is there any history of skin reaction or other illness following contact with:	No	Yes	Description
1.	Penicillin, Sulfa or other antibiotic?	☐	☐	
2.	Morphine, Codine, Demerol or narcotic?	☐	☐	
3.	Novocain, Lidocaine or local anesthetics?	☐	☐	

4.	Tetanus toxoid or serums?	☐	☐	
5.	Adhesive tape?	☐	☐	
6.	Iodine, Betadine, Chlorhexidine or Phisophex?	☐	☐	
7.	Tincture or Benzoin?	☐	☐	
8.	Latex rubber?	☐	☐	
9.	Other drug medicine of other substance?	☐	☐	

Section VII: Review of Systems

General	No	Yes
1. Tire easily, weakness	☐	☐
2. Night sweats	☐	☐
3. Persistent fever	☐	☐
4. Sensitivity to cold or hot	☐	☐
5. Irritability	☐	☐
6. Sleeplessness	☐	☐
7. Marked recent weight loss	☐	☐

Skin	No	Yes
1. Eruptions (rash)	☐	☐
2. Change in color	☐	☐
3. Change in nails	☐	☐

Eyes	No	Yes
1. Trouble seeing	☐	☐
2. Eye pain	☐	☐
3. Inflamed eyes	☐	☐
4. Double vision	☐	☐
5. Blurred vision	☐	☐
6. Discharge	☐	☐

Ears	No	Yes
1. Loss of hearing	☐	☐
2. Ringing in ears	☐	☐
3. Discharge	☐	☐
4. Dizziness, vertigo	☐	☐

Cardiovascular System	No	Yes
1. Chest pain or discomfort	☐	☐
2. Difficulty breathing while lying down	☐	☐
3. Bluish fingers or lips	☐	☐
4. High blood pressure	☐	☐
5. Vein trouble	☐	☐
6. Palpitations	☐	☐

Digestive System	No	Yes
1. Difficulty swallowing	☐	☐
2. Heartburn	☐	☐
3. Abdominal distress	☐	☐
4. Belching or excessive gas	☐	☐
5. Nausea	☐	☐
6. Vomiting	☐	☐
7. Rectal bleeding	☐	☐
8. Tarry stools	☐	☐
9. Jaundice	☐	☐
10. Constipation	☐	☐
11. Diarrhea	☐	☐
12. Hemorrhoids	☐	☐
13. Change in appetite	☐	☐

Genitourinary System	No	Yes
1. Increase in frequency of urination	☐	☐
2. Feel need but not much urine	☐	☐

Nose	No	Yes
1. Loss of smell	☐	☐
2. Frequent colds	☐	☐
3. Obstruction	☐	☐
4. Excess discharge	☐	☐
5. Nosebleeds	☐	☐

Mouth	No	Yes
1. Sore gums	☐	☐
2. Major dental problems	☐	☐
3. Bleeding gums	☐	☐

Throat	No	Yes
1. Postnasal drainage	☐	☐
2. Soreness	☐	☐
3. Hoarseness	☐	☐
4. Voice change	☐	☐

Breast	No	Yes
1. Lumps	☐	☐
2. Discharge	☐	☐

Respiratory System	No	Yes
1. Cough, persisting	☐	☐
2. Sputum (phlegm)	☐	☐
3. Bloody sputum	☐	☐
4. Wheezing	☐	☐
5. Pain on breathing	☐	☐

3. Unable to hold urine	☐	☐
4. Pain or burning	☐	☐
5. Blood in urine	☐	☐

Endocrine	No	Yes
1. Thyroid trouble	☐	☐
2. Adrenal trouble	☐	☐
3. Cortisone treatment	☐	☐
4. Diabetes	☐	☐

Musculoskeletal	No	Yes
1. Muscle cramps	☐	☐
2. Weakness of muscles	☐	☐
3. Pain in joints	☐	☐
4. Stiffness	☐	☐
5. Deformity of joints	☐	☐

Nervous System	No	Yes
1. Headaches	☐	☐
2. Fainting	☐	☐
3. Convulsions or fits	☐	☐
4. Change in sensation	☐	☐
5. Memory loss	☐	☐
6. Poor coordination	☐	☐
7. Depression	☐	☐
8. Nervousness	☐	☐

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____