



## 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 Linea Cosmetic Surgery 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 Linea Cosmetic Surgery you are hereby agreeing to pay all charges, at the time of services or when otherwise informed. Further, you agree that Linea Cosmetic Surgery 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 Linea Cosmetic Surgery.

\_\_\_\_\_  
Patient or Guarantor Signature

\_\_\_\_\_  
Date



**Procedures or Products of Interest**

- |   |  |   |   |
|---|--|---|---|
| <p><b>Body:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Liposuction / Lipocontouring</li> <li><input type="checkbox"/> Body contouring after major weight loss</li> <li><input type="checkbox"/> Tummy tuck</li> <li><input type="checkbox"/> Buttock lift</li> <li><input type="checkbox"/> Thigh lift</li> <li><input type="checkbox"/> Buttock enlargement (Brazilian Butt Lift)</li> <li><input type="checkbox"/> Correction of tummy tuck or liposuction</li> <li><input type="checkbox"/> Arm lift</li> <li><input type="checkbox"/> Body lift</li> <li><input type="checkbox"/> Hernia repair</li> <li><input type="checkbox"/> Labia repair</li> <li><input type="checkbox"/> Other:</li> </ul> | <p><b>Breast:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Breast enlargement</li> <li><input type="checkbox"/> Breast implant revision</li> <li><input type="checkbox"/> Breast reduction</li> <li><input type="checkbox"/> Breast lift</li> <li><input type="checkbox"/> Breast lift with enlargement</li> <li><input type="checkbox"/> Nipple reduction</li> <li><input type="checkbox"/> Correction of inverted nipples</li> <li><input type="checkbox"/> Male chest reduction</li> </ul> | <p><b>Face:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Nose surgery</li> <li><input type="checkbox"/> Breathing problems</li> <li><input type="checkbox"/> Eyelid lift</li> <li><input type="checkbox"/> Brow lift</li> <li><input type="checkbox"/> Face lift</li> <li><input type="checkbox"/> Ear pinning</li> <li><input type="checkbox"/> Neck lift or liposuction</li> <li><input type="checkbox"/> Chin enlargement</li> <li><input type="checkbox"/> Buccal fat removal</li> </ul> | <p><b>In Office:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Botox</li> <li><input type="checkbox"/> Juvederm</li> <li><input type="checkbox"/> Latisse</li> <li><input type="checkbox"/> Skin care</li> <li><input type="checkbox"/> Scar revision</li> <li><input type="checkbox"/> Mole removal</li> </ul> |
|---|--|---|---|

**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:		<b>No</b>	<b>Yes</b>	<b>Description</b>
2.	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
4.	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
5.	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
6.	Hepatitis or Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
7.	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
8.	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
9.	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
10.	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
11.	Problem Scarring	<input type="checkbox"/>	<input type="checkbox"/>	_____



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	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.	Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
4.	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
5.	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
6.	Repeated Infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
7.	Chronic Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
8.	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
9.	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
10.	Severe Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
11.	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
12.	Crippling Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
13.	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
14.	Convulsions or Fits	<input type="checkbox"/>	<input type="checkbox"/>	_____
15.	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
16.	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
17.	Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____
18.	Thyroid Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
19.	Obesity	<input type="checkbox"/>	<input type="checkbox"/>	_____

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



**Section V: Medications**

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

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

**Medications that cause bleeding:** Do you take any of the following on a regular basis:

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

**Section VI: Allergies and Sensitivities**

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

Is there any history of skin reaction or other illness following contact with:		No	Yes	Description
1.	Penicillin, Sulfa or other antibiotic?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.	Morphine, Codine, Demerol or narcotic?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.	Novocain, Lidocaine or local anesthetics?	<input type="checkbox"/>	<input type="checkbox"/>	_____



- |  |                          |                          |       |
|--|--------------------------|--------------------------|-------|
| 4. Tetanus toxoid or serums?                     | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Adhesive tape?                                | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. Iodine, Betadine, Chlorhexidine or Phisophex? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 7. Tincture or Benzoin?                          | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 8. Latex rubber?                                 | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 9. Other drug medicine of other substance?       | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| _____  |                          |                          | _____ |
| _____  |                          |                          | _____ |

**Section VII: Review of Systems**

<b>General</b>	<b>No</b>	<b>Yes</b>	<b>Cardiovascular System</b>	<b>No</b>	<b>Yes</b>	
1. Tire easily, weakness	<input type="checkbox"/>	<input type="checkbox"/>	1. Chest pain or discomfort	<input type="checkbox"/>	<input type="checkbox"/>	
2. Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	2. Difficulty breathing while lying down	<input type="checkbox"/>	<input type="checkbox"/>	
3. Persistent fever	<input type="checkbox"/>	<input type="checkbox"/>	3. Bluish fingers or lips	<input type="checkbox"/>	<input type="checkbox"/>	
4. Sensitivity to cold or hot	<input type="checkbox"/>	<input type="checkbox"/>	4. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
5. Irritability	<input type="checkbox"/>	<input type="checkbox"/>	5. Vein trouble	<input type="checkbox"/>	<input type="checkbox"/>	
6. Sleeplessness	<input type="checkbox"/>	<input type="checkbox"/>	6. Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	
7. Marked recent weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<b>Digestive System</b>		<b>No</b>	<b>Yes</b>
<b>Skin</b>	<b>No</b>	<b>Yes</b>	1. Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	
1. Eruptions (rash)	<input type="checkbox"/>	<input type="checkbox"/>	2. Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	
2. Change in color	<input type="checkbox"/>	<input type="checkbox"/>	3. Abdominal distress	<input type="checkbox"/>	<input type="checkbox"/>	
3. Change in nails	<input type="checkbox"/>	<input type="checkbox"/>	4. Belching or excessive gas	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Eyes</b>	<b>No</b>	<b>Yes</b>	5. Nausea	<input type="checkbox"/>	<input type="checkbox"/>	
1. Trouble seeing	<input type="checkbox"/>	<input type="checkbox"/>	6. Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
2. Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	7. Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
3. Inflamed eyes	<input type="checkbox"/>	<input type="checkbox"/>	8. Tarry stools	<input type="checkbox"/>	<input type="checkbox"/>	
4. Double vision	<input type="checkbox"/>	<input type="checkbox"/>	9. Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	
5. Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	10. Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
6. Discharge	<input type="checkbox"/>	<input type="checkbox"/>	11. Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Ears</b>	<b>No</b>	<b>Yes</b>	12. Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	
1. Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	13. Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	
2. Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	<b>Genitourinary System</b>		<b>No</b>	<b>Yes</b>
3. Discharge	<input type="checkbox"/>	<input type="checkbox"/>	1. Increase in frequency of urination	<input type="checkbox"/>	<input type="checkbox"/>	
4. Dizziness, vertigo	<input type="checkbox"/>	<input type="checkbox"/>	2. Feel need but not much urine	<input type="checkbox"/>	<input type="checkbox"/>	



<b>Nose</b>	<b>No</b>	<b>Yes</b>
1. Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>
2. Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>
3. Obstruction	<input type="checkbox"/>	<input type="checkbox"/>
4. Excess discharge	<input type="checkbox"/>	<input type="checkbox"/>
5. Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>

<b>Mouth</b>	<b>No</b>	<b>Yes</b>
1. Sore gums	<input type="checkbox"/>	<input type="checkbox"/>
2. Major dental problems	<input type="checkbox"/>	<input type="checkbox"/>
3. Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>

<b>Throat</b>	<b>No</b>	<b>Yes</b>
1. Postnasal drainage	<input type="checkbox"/>	<input type="checkbox"/>
2. Soreness	<input type="checkbox"/>	<input type="checkbox"/>
3. Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
4. Voice change	<input type="checkbox"/>	<input type="checkbox"/>

<b>Breast</b>	<b>No</b>	<b>Yes</b>
1. Lumps	<input type="checkbox"/>	<input type="checkbox"/>
2. Discharge	<input type="checkbox"/>	<input type="checkbox"/>

<b>Respiratory System</b>	<b>No</b>	<b>Yes</b>
1. Cough, persisting	<input type="checkbox"/>	<input type="checkbox"/>
2. Sputum (phlegm)	<input type="checkbox"/>	<input type="checkbox"/>
3. Bloody sputum	<input type="checkbox"/>	<input type="checkbox"/>
4. Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
5. Pain on breathing	<input type="checkbox"/>	<input type="checkbox"/>

3. Unable to hold urine	<input type="checkbox"/>	<input type="checkbox"/>
4. Pain or burning	<input type="checkbox"/>	<input type="checkbox"/>
5. Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>

<b>Endocrine</b>	<b>No</b>	<b>Yes</b>
1. Thyroid trouble	<input type="checkbox"/>	<input type="checkbox"/>
2. Adrenal trouble	<input type="checkbox"/>	<input type="checkbox"/>
3. Cortisone treatment	<input type="checkbox"/>	<input type="checkbox"/>
4. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>

<b>Musculoskeletal</b>	<b>No</b>	<b>Yes</b>
1. Muscle cramps	<input type="checkbox"/>	<input type="checkbox"/>
2. Weakness of muscles	<input type="checkbox"/>	<input type="checkbox"/>
3. Pain in joints	<input type="checkbox"/>	<input type="checkbox"/>
4. Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
5. Deformity of joints	<input type="checkbox"/>	<input type="checkbox"/>

<b>Nervous System</b>	<b>No</b>	<b>Yes</b>
1. Headaches	<input type="checkbox"/>	<input type="checkbox"/>
2. Fainting	<input type="checkbox"/>	<input type="checkbox"/>
3. Convulsions or fits	<input type="checkbox"/>	<input type="checkbox"/>

4. Change in sensation	<input type="checkbox"/>	<input type="checkbox"/>
5. Memory loss	<input type="checkbox"/>	<input type="checkbox"/>
6. Poor coordination	<input type="checkbox"/>	<input type="checkbox"/>
7. Depression	<input type="checkbox"/>	<input type="checkbox"/>
8. Nervousness	<input type="checkbox"/>	<input type="checkbox"/>

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

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_