

SHAPE

Cosmetic Surgery & MedSpa

John Lundeby, MD FACS, FAACS
524 West 6th Avenue, Spokane, WA 99204
Phone: 509-458-7546 * Fax: 509-444-2877

Patient Information (Please print)

Today's date: _____

Name _____ SS# _____ DOB: _____ Age _____
Last MI First

Address _____ City _____ State _____ Zip _____

Occasionally we like to send tokens of appreciation to our patients at their home. May we do so for you? Yes No

Sex: Female Male Are you: Minor Married Divorced Widowed Single Separated

Home ph: _____ Cell ph: _____ It is OK to leave voicemail on either of these #'s? Yes No

Email address: _____

Your employer _____ Occupation _____ Work phone: _____

Business address _____ City _____ State _____ Zip _____

Spouse's name _____ Workplace _____ Work phone # _____

Person to contact in case of emergency _____ Phone # _____

Who is your Primary Care Doctor? _____

Which of our procedures are you here to obtain additional information about?

SmartLipo _____ Breast Augmentation _____ Other _____

Which problem areas are you considering having treated? _____

Have you had cosmetic procedures in the past? No Yes

If "Yes", please list with dates and areas: _____

How did you hear about us?

Website _____ Magazine _____ Newspaper _____ Billboard _____ Friend _____
TV Commercial _____ Walk-In _____ Patient Referral _____
Already an existing client _____ Other _____

HEALTH HISTORY

Patient name: _____ Birthdate: _____ Height: _____ Weight: _____

Chief Complaint: _____ Where is pain/problem ? _____

Does the pain/problem occur at a specific time? _____ How long have you had the pain/problem? _____

What makes the pain/problem worse or better? or, Have you had previous episodes? _____

Past Medical History

Have you ever had the following: (Circle "no" or "yes")

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder infections.....	no	yes	High Blood Pressure..	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure...	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine headaches...	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Asthma	no	yes	Any other disease?	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Hives or Eczema	no	yes	(please list):	_____	
Smallpox.....	no	yes	Cancer.....	no	yes	AIDS or HIV+.....	no	yes	_____	_____	
Pneumonia.....	no	yes	Polio.....	no	yes	Infectious Mono.....	no	yes	_____	_____	
Rheumatic Fever.....	no	yes	Glaucoma.....	no	yes	Bronchitis.....	no	yes	_____	_____	
Heart Disease.....	no	yes	Hernia.....	no	yes	Mitral Valve Prolapse	no	yes	_____	_____	
Arthritis.....	no	yes	Blood or plasma			Stroke.....	no	yes	_____	_____	
Venereal Disease.....	no	yes	transfusions.....	no	yes	Bleeding tendency.....	no	yes	_____	_____	
Post-operative			Motion sickness	no	yes	Date last chest x-ray:	_____	_____			
nausea.....	no	yes									

Previous Cosmetic Procedures no yes If Yes, any complications? _____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (Include nonprescription) _____

Allergies:

Penicillin or other antibiotics	no	yes	Other allergies (drugs, medications, foods, environmental)
Morphine, Demerol, or other narcotics	no	yes	_____
Novocain or other anesthetics	no	yes	_____
Aspirin or other pain remedies	no	yes	_____
Tetanus antitoxin or other serums	no	yes	_____
Iodine, Merthiolate or other antiseptic	no	yes	_____

Patient social history:

Marital status..... Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Use of alcohol..... Never _____ Rarely _____ Moderate _____ Daily _____

Use of tobacco..... Never _____ Previously but quit _____ Current packs / day _____

Use of drugs..... Never _____ Type/Frequency: _____

Excessive exposure at work or home to ... Fumes _____ Dust _____ Solvents _____ Air-borne particles _____ Noise _____

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

Please indicate any personal history below:

Constitutional Symptoms

Good general health lately..... no yes
 Recent weight change..... no yes
 Fever..... no yes
 Headaches..... no yes

Eyes

Eye disease or injury..... no yes
 Wear glasses/contact lenses..... no yes
 Blurred or double vision..... no yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing..... no yes
 Earaches or drainage..... no yes
 Chronic sinus problem or rhinitis..... no yes
 Nose bleeds..... no yes
 Mouth sores..... no yes
 Bleeding gums..... no yes

Bad breath or bad taste..... no yes
 Sore throat or voice change..... no yes
 Swollen glands in neck..... no yes

Cardiovascular

Heart trouble..... no yes
 Chest pain or angina pectoris..... no yes
 Palpitation..... no yes
 Shortness of breath w/walking or lying flat..... no yes
 Swelling of feet, ankles, or hands..... no yes

Musculoskeletal

Joint pain..... no yes
 Joint stiffness or swelling..... no yes
 Weakness of muscles or joints..... no yes
 Back pain..... no yes
 Cold extremities..... no yes
 Difficulty in walking..... no yes

Neurological

Frequent or recurring headaches..... no yes
 Light headed or dizzy..... no yes
 Convulsions or seizures..... no yes
 Numbness or tingling sensations..... no yes
 Paralysis..... no yes
 Head injury..... no yes

Genitourinary

Frequent urination..... no yes
 Burning or painful urination..... no yes
 Blood in urine..... no yes
 Change in force of strain when urinating..... no yes
 Incontinence or dribbling..... no yes
 Kidney stones..... no yes
 Sexual difficulty..... no yes
 Male – testicle pain..... no yes
 Female – irregular periods..... no yes
 Female – vaginal discharge..... no yes
 Female - # of pregnancies..... _____
 Female - # of miscarriages..... _____
 Female – date of last pap smear..... _____

Respiratory

Chronic or frequent coughs..... no yes
 Spitting up blood..... no yes
 Shortness of breath..... no yes
 Wheezing..... no yes

Integumentary (skin, breast)

Rash or itching..... no yes
 Change in skin color..... no yes
 Change in hair or nails..... no yes
 Varicose veins..... no yes
 Current Breast pain..... no yes
 Breast lump..... no yes
 Breast discharge..... no yes

Gastrointestinal

Loss of appetite..... no yes
 Change in bowel movements..... no yes
 Nausea or vomiting..... no yes
 Frequent diarrhea..... no yes
 Painful bowel movements or constipation..... no yes
 Rectal bleeding /blood in stool..... no yes
 Abdominal pain..... no yes

Psychiatric

Memory loss or confusion..... no yes
 Nervousness..... no yes
 Depression..... no yes
 Insomnia..... no yes

Endocrine

Glandular or hormone problem..... no yes
 Excessive thirst or urination..... no yes
 Heat or cold intolerance..... no yes
 Skin becoming dryer..... no yes
 Change in hat or glove size..... no yes

Hematologic/lymphatic

Slow to heal after cuts..... no yes
 Bleeding or bruising tendency..... no yes
 Anemia..... no yes
 Phlebitis..... no yes
 Past transfusion..... no yes
 Enlarged glands..... no yes

Please answer questions below if you are a woman and over 35 years of age:

Do you have a history of ductal carcinoma in situ or lobular carcinoma in situ? _____

Age of your first menstrual period? _____

Age at the first live birth of a child (enter 0 if none) _____

Number of first degree relative (mother and/or sister and/or daughter) have had breast cancer? _____

Have you ever had a breast biopsy? _____ How many breast biopsies? _____

Have any of your biopsies shown “atypical hyperplasia”? _____

What is your race? (“white”, “black”, or “Asian” – If you do not answer or are another race, the computer will calculate your risk as white) _____

Have you ever taken birth control pills? _____ If yes, for how long? _____

Have you ever been on hormone replacement therapy? _____ If yes, for how long? _____

Do you have a history of breast pain? _____ History of breast injury? _____

If yes, please explain _____

Doctor comments

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

 Name of Patient (please print)

 Signature of Patient, Parent, or Guardian

 Date