finesse COSMETIC SURGERY

Medical History

Last Name:_____ First Name:_____ M.I.:_____ Date:_____

Street:_____

Town:_____ State:_____ Zip:_____

Phone Numbers- Home:_____ Work:_____ Cell:_____
Please circle which number you'd prefer confirmation calls: Home / Work / Cell

D.O.B.:_____ Age_____ How did you hear about us?_____

Do you give us permission to contact you via email/text? (i.e. confirmations, appointment follow ups and promotions?) Y N

Email: _____

Emergency Contact Name and Phone Number: _____

Lifestyle:	Please Circle		
Smoking	Y	N	Amnt (per week): _____
Alcohol	Y	N	Amnt (per month: _____
Rec Drugs	Y	N	Amnt (per month):_____
Caffeine	Y	N	Amnt (per day): _____
Exercise	Y	N	Amnt (per week): _____

Please indicate if you've had the following:

CoolSculpting: □	Kybella: □	Mesotherapy: □
Laser Treatments: □	Depilatories: □	Chemical Peels: □
Tanning Beds: □	Electrolysis: □	Microderm: □
Waxing: □	Cosmetic Surgery: □	Retin-A/Renova: □
Tweezing: □	Botox/Filler: □	Accutane: □ When:_____

Occupation: _____ Please tell us your ethnicity/descent:_____

When was the last time you had a physical exam:_____
Name/Number of Primary Physician:_____

Height:_____ Weight:_____ Have you had any significant weight change in the last year? Y / N
How many pounds have you lost or gained in the last year? (CIRCLE ONE) **+ / -** _____lbs

Please list ALL Allergies that you have:_____

Have you ever received any blood transfusions? Y N If yes, when? _____
Medical History: **Please Circle Y or N whether you have or have ever had the following:**

Abnormal Bleeding	Y	N	Asthma/Difficulty Breathing	Y	N	Kidney/Liver Disease	Y	N
Abnormal Clotting	Y	N	Diabetes	Y	N	Auto Immune Disorder	Y	N
Acid Reflux	Y	N	Dizziness/fainting	Y	N	Arrhythmias	Y	N
Anemia	Y	N	Heart Attack	Y	N	Intestinal Problems	Y	N
Angina (chest pain)	Y	N	High Blood Pressure	Y	N	Difficulty Breathing	Y	N
Epilepsy (seizures)	Y	N	Thyroid problems	Y	N	Psychological Illness	Y	N
Sleep Apnea	Y	N	Tuberculosis	Y	N	HIV	Y	N
Cancer	Y	N	Pigment changes after skin injury	Y	N	Hernia	Y	N
Eating Disorder	Y	N	Poor wound healing	Y	N	Hepatitis	Y	N

*Please explain reasons for circling yes to any of the above or please explain other conditions you have that are not listed above:_____

Have any of your immediate family members ever had any of the above health issues? Y / N
If yes please explain:_____

Do you experience Cold Sores: Y / N Last Outbreak: _____

Do you wear (Please Circle Y or N): Contacts/Glasses: Y / N Hearing Aid: Y / N Dentures: Y / N

Have you consulted with any other surgeon: Y / N

Do you understand that the object of any cosmetic procedure is improvement in appearance, not perfection: Y / N

Do you realize that every operation is followed by a period of healing before the tissue returns to normal and the final result is apparent: Y / N

Surgery: Please list any previous surgeries and their dates (including cosmetic surgery):

_____

_____

If you have had cosmetic surgery, were you happy with the results? Y / N If NO please explain:_____
_____

Have you ever done CoolSculpting, Ultrashape, Liposonix, Kybella, or any other non-surgical fat reduction treatment? _____

Indicate the type(s) of anesthesia received in the past; specify any complications/reactions you may have experienced:

Local	Y____	N____	Reactions:_____
General	Y____	N____	Reactions:_____
Spinal/Epidural	Y____	N____	Reactions:_____

<u>Female patients:</u>

Number of pregnancies:_____ Did you breast feed? Y____ N____ Date of last period:_____

I acknowledge that I have disclosed my complete medical history and the above is complete and accurate to my knowledge of my medical and psychological status.

I am at least 18 years of age or, if not, I am accompanied by a legal guardian. I hereby consent to and authorize that a medical history be taken by the Finesse Cosmetic Surgery. In order to evaluate and plan and help educate me on the possibilities of procedures I can be offered, I understand that photos are helpful and I authorize the taking of photos, which *will be used solely for documentation and be kept confidential.*

Signature: _____ Date:_____
If under 18: Relationship: (circle) Patient Spouse Parent Guardian Signature:_____

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Medications

Client Information:

Name: _____

Allergies: _____

Pharmacy Contact Information:

Pharmacy Name:_____ Pharmacy Phone #:_____

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

*If you do not know the address, please provide at least the Street name and City.

Instructions: **List all medications you are currently taking or have taken within the last sixty (60) days. Fill out thoroughly.**

1. ***If you're not currently taking any medications leave page blank***. **Do not cross out.**
2. Include all prescription and over-the-counter medications (example: antibiotics, aspirin, antacids), herbal supplements (example: ginseng, ginko), and vitamins (example: multivitamin, Vitamin E). Include medications taken as needed (example: nitroglycerin). Also, include any injections you may have received (example: steroids) in the last two (2) months.
3. Each visit we will have you update this form. At subsequent visits CROSS OFF any medications you no longer take. Indicate the date you stopped taking the medications.
4. NEVER take drugs prescribed for someone else.

Medication List:

Name of Medication, Dose, & Route (Pill? Injections? Other?)	Directions (How many times/day do you take this & when)	Date prescribed	Date stopped	Medication held due to Procedure?		Reasons for taking this Medication
				Y	N	
				Y	N	
				Y	N	
				Y	N	
				Y	N	
				Y	N	
				Y	N	
				Y	N	
				Y	N	

I acknowledge that I have disclosed my complete medication history and the above is complete and accurate to my knowledge of my medical and psychological status.

Signature:_____

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Practice Policy Statement

A Credit Card Number is required to reserve your appointment.

We require at least 24 hours notice for appointment cancellations or reschedules. If you cancel or reschedule your appointment with less than 24 hours notice or fail to come to your appointment, a $75 charge will be applied to your credit card.

Payment Policy:

We require payment in full at the time that services are rendered or products are purchased. We gladly accept cash, a all major credit cards and certified checks. WE DO NOT ACCEPT PERSONAL CHECKS. We also offer financing for certain services (minimum dollar amounts apply) through Care Credit. You must be approved by the respective finance company to finance a service. Injectable treatments and products are offered with 6 months no-interest terms only (again minimum dollar amounts apply).

Refund Policy:

Finesse Cosmetic Surgery will not issue refunds for services purchased or rendered. We may, at our sole discretion, issue a full or partial clinic credit for use at our facility. We are committed to setting realistic expectations; however, results vary. Though we do our best to achieve your desired, realistic outcome, we do not issue a refund or credit after treatments are purchased or rendered. Any packages not completed within one year of purchase date forfeit the remaining treatments. Any deposits not used within 6 months of payment are forfeited. Our products may be exchangeable for products, clinic credit, or monetary refund at our sole discretion. ZO products are not exchangeable or refundable.

Please note that quotes and deposits are valid for 30 days

Accepted and agreed to:

_____

Client Signature **Date**

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Patient Acknowledgement of Disclosure Information

My signature below acknowledges the following:

I am aware that I can access Finesse Cosmetic Surgery's

- **Patient Bill of Rights**
- **Privacy Notice**
- **Practice Disclosure**

on their website at www.finesselaser.com. I am aware that the Privacy Notice is also posted in the waiting room. I acknowledge that I can request a hard copy of any of these documents at any time. I have had an opportunity to receive assistance in understanding these documents and have been given the opportunity to ask questions as may be needed.

I also understand this practices position on Do Not Resuscitate (DNR) and Living Wills and that this practice does not honor these directives.

Name of Patient/Representative (please print)_____

Signature of Patient/Representative_____

Date:_____

Above signature was not obtained because:
☐Patient is unable and unaccompanied by a representative.
☐Patient refused to sign

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COVID 19 Screening Questionnaire

Check-In

YES/NO

- Have you been in direct contact or cared for anyone with COVID-19? _____

- Have you traveled outside of the state of Massachusetts in the past 2 weeks? _____

- Are you experiencing any of the following symptoms:

Fever, feeling feverish of excessive sweating _____

Sore throat _____

New cough (not related to seasonal allergies) _____

Muscle aches (not related to chronic conditions) _____
New loss of smell or taste _____

Shortness of breath _____

Signature:_____ Date:_____