Paige C. Holt MD ◆ Glori Traeder CNP

Plastic Surgery & Aesthetics

Personal Information

Date: ______________________ Name: ____

Date of Birth: ________________ Age: __________ Occupation: ____________________________

Address: ____________________________ City: __________________ State: ______ Zip: _________

Home Phone: (____) _____ - _______ Work Phone: (____) ____ - _______ Cell Phone: (____) ____ - ________

Email address: ____

Emergency Contact Name and Phone: _____________________________ Relationship _____________

How did you hear about us? ____

What is the nature of your visit? ____

Medical History

Height: ______________ Weight: ______________ Primary care provider: ____________________

Are you allergic to any medication, latex or local anesthesia? ☐ No ☐ Yes, please list with reaction:

____

____

Have you or do you still have: (Please check all that apply.)

☐ Cancer ☐ Asthma ☐ Skin Disease / Skin Lesions ☐ High Blood Pressure

☐ HIV/AIDS ☐ Heart trouble ☐ Neurologic Disease ☐ Pacemaker/Defibrillator

☐ Stroke ☐ Seizure Disorder ☐ Frequent Cold Sores ☐ Any Active Infection

☐ Diabetes ☐ Arthritis ☐ Hormone Imbalance ☐ Thyroid Imbalance

☐ Hepatitis ☐ Herpes ☐ Keloid Scarring ☐ Problem Scarring ☐ Blood Clotting Abnormalities

☐ Others Not Listed: ____

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

____

____

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

____

____

Have you received a COVID-19 vaccination? ☐ No ☐ Yes, please list date of final dose: __________________

Have you been in close physical contact in the last 14 days with anyone who is known to have any symptoms consistent with, or laboratory-confirmed COVID-19? ☐ No ☐ Yes, please describe: __________________

____

Do you have any reason to believe you, or any member of your household, have been exposed to or acquired COVID-19 within the last 14 days? ☐ No ☐ Yes

Social History

Do you smoke? ☐ No ☐ Yes, how much? ____

Previous smoking history? ☐ No ☐ Yes, how long ago? ______________________________

Do you drink? ☐ No ☐ Yes, how much? ____

Do you regularly sun bathe or use tanning salons? _______ How Often? ____________________

Sun Exposure History: ____

Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list with dose and frequency:

____

____

____

____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No:

Constitutional symptoms:
- Fever Y N
- Chills Y N
- Headache Y N
- Other ____________

Ears, Nose, Throat:
- Hearing Loss Y N
- Sneezing Y N
- Congestion Y N
- Other ____________

Cardiovascular:
- Chest Pain Y N
- Shortness of Breath Y N
- Cough Y N
- Other ____________

Neurological:
- Dizziness Y N
- Numbness/Tingling in Arms or Legs Y N
- Frequent Headaches Y N
- Other ____________

Lymphatics:
- Enlarged Lymph Nodes Y N
- Other ____________

Psychiatric:
- Depression Y N
- Anxiety Y N
- Other ____________

Gastrointestinal:
- Anorexia Y N
- Nausea/Vomiting Y N
- Abdominal Pain Y N
- Other ____________

Eyes:
- Blurred Vision Y N
- Visual Loss Y N
- Double Vision Y N
- Other____________

Skin:
- Itchy skin Y N
- Rash Y N
- Hives Y N
- Other ____________

Hematologic:
- Anemia Y N
- Bruising Y N
- Bleeding Y N
- Other ____________

Genitourinary:
- Painful Urination Y N
- Urination Incontinence Y N
- Other ____________

Musculoskeletal:
- Muscle Pain Y N
- Back Pain Y N
- Joint Pain Y N
- Other ____________

Endocrine:
- Night Sweats Y N
- Hot/Cold Intolerance Y N
- Other ____________

Family History

Have any blood relatives had any pertinent medical history including:

Cancer ☐ No ☐ Yes Describe: ____________________

Bleeding Tendency ☐ No ☐ Yes Describe: ____________________

Leukemia ☐ No ☐ Yes Describe: ____________________

Heart Disease ☐ No ☐ Yes Describe: ____________________

High Blood Pressure ☐ No ☐ Yes Describe: ____________________

Repeated Infections ☐ No ☐ Yes Describe: ____________________

Chronic Lung Disease ☐ No ☐ Yes Describe: ____________________

Tuberculosis ☐ No ☐ Yes Describe: ____________________

Asthma ☐ No ☐ Yes Describe: ____________________

Severe Allergies ☐ No ☐ Yes Describe: ____________________

Kidney Disease ☐ No ☐ Yes Describe: ____________________

Arthritis ☐ No ☐ Yes Describe: ____________________

Mental Illness ☐ No ☐ Yes Describe: ____________________

Convulsions ☐ No ☐ Yes Describe: ____________________

Migraine Headaches ☐ No ☐ Yes Describe: ____________________

Diabetes ☐ No ☐ Yes Describe: ____________________

Gout ☐ No ☐ Yes Describe: ____________________

Thyroid Trouble ☐ No ☐ Yes Describe: ____________________

Heart Surgery ☐ No ☐ Yes Describe: ____________________

Obesity ☐ No ☐ Yes Describe: ____________________

For Female Clients:

Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

Are you breastfeeding? ☐ No ☐ Yes

Are you using contraception? ☐ No ☐ Yes

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature: ____________________ Date: ____________

<u>Consent to Communicate</u>

Patient Name: ____

Please mark the ways that you consent to us communicating with you:

Method	Ok to leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)
□ Call Work Phone	□ Yes □ No	□ Yes □ No	☐
□ Call Cell Phone	□ Yes □ No	□ Yes □ No	☐
□ Call Home Phone	□ Yes □ No	□ Yes □ No	☐
□ Send email	-	-	☐

□ Email Appts Reminders □ Email Medical Info □ Email Marketing Info

Mail to which Address: □ Home □ Other (please list):

____

If it is ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			□ Yes □ No	
			□ Yes □ No	

Signature: ____________________________________ Date: __________________

Privacy Policy

This is the privacy policy of Paige C. Holt, MD, and Glori Traeder, CNP, Plastic Surgery & Aesthetics. The staff of Quincy Plastic Surgery & Aesthetics work diligently every day to respect the privacy of your personal information. Please take a moment to familiarize yourself with what information we collect, how we protect it, and how we use it.

- The staff has been trained in the importance of maintaining your confidentiality and enforces the facility's privacy rules.
- We only collect information which is pertinent to providing you with quality care.
- We will maintain physical, electronic, and procedural safeguards to protect personal information we obtain about you.
- We will respect your expressed desire not to share certain information. You may so direct at any time.
- If at any time you should feel that your privacy is being compromised, please let the Practice manager know immediately.

Thank you for allowing Dr. Paige Holt, Glori Traeder, CNP, and the staff of Quincy Plastic Surgery & Aesthetics the opportunity to assist you in achieving your plastic, reconstruction and aesthetic surgery goals.

I acknowledge that I have received or been offered the **HIPPA Notice of Privacy Practices** of Quincy Plastic Surgery & Aesthetic effective July 1, 2015. I understand that the Notice describes the uses of my protected health information by the Covered Entities which collectively constitute Quincy Plastic Surgery & Aesthetics and informs me of my rights with respect to my protected health information.

____
Name of Patient   Date of Birth

____
Signature of Patient or Personal Representative   Date

____
Printed Name of Patient or Personal Representative

If personal Representative, indicate relationship:

____

Declinations

__________ The Individual declined to accept a copy of the Notice of Privacy Practices.

__________ The Individual received a copy of the Notice of Privacy Practices, but declined to sign an Acknowledgement of Receipt.

Photograph Consent and Release

I, ____ hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery or a procedure. The photographs will be taken by one of the members of Paige C. Holt MD Plastic Surgery and Aesthetics and Glori Traeder CNP medical staff. I hereby give my consent for Paige C. Holt MD Plastic Surgery and Aesthetics and Glori Traeder CNP to use the photographs under one of the following circumstances.

Please initial ONE of the following:

_____ **Medical Care Only:** Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Paige C. Holt MD Plastic Surgery and Aesthetics and Glori Traeder CNP. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Paige C. Holt MD and Glori Traeder CNP Plastic Surgery & Aesthetics

______ **Internet:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Paige C. Holt MD and Glori Traeder CNP Plastic Surgery & Aesthetics can be used on the company's website in order to inform the public about plastic surgery methods. Further, I release and discharge Paige C. Holt MD and Glori Traeder CNP Plastic Surgery & Aesthetics and any employees of Paige C. Holt MD and Glori Traeder CNP Plastic Surgery & Aesthetics and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claims for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during any use or publication of these materials by any party.

_____ **All Media:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received Paige C. Holt MD and Glori Traeder CNP Plastic Surgery & Aesthetics can be used in any print or broadcast media, including, but not limited to newspapers, pamphlets, educational films, internet, and television, in order to inform the public about plastic surgery methods. Further, I release and discharge Paige C. Holt MD, Glori Traeder CNP and any employees of Paige C. Holt MD and Glori Traeder CNP Plastic Surgery & Aesthetics and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

By signing this form, I acknowledge my consent as initialed above, and further recognize that this consent form will supersede any other photo consent form with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

Signature *(Patient or Parent/Guardian if patient is under 18)* Date Witness Signature