Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Street) (City) (State) (zip code)*

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone:­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone:­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Soc. Sec.#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ Sex:\_\_\_\_\_ Marital Status\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Referring Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Family Physician:­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance Information**

Name of Insured:­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Soc. Sec.#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Information**

Name of Insured:­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Soc. Sec.#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
I hereby authorize Aaron Capuano, M.D., F.A.C.S. and his representatives to release any information acquired in the course of medical examination, surgery/treatment for insurance claim filing. Photocopy of this signed authorization shall be considered as effective and valid as the original.

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

Health History (Please check below for any conditions that you are experiencing or have experienced)

General

* Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Current weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Goal weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Maximum weight \_\_\_\_\_\_\_\_\_\_\_\_
* History of recent weight gain/loss
* History of malignant hyperthermia
* History of traumatic injury

Cosmetic History

* Prior history of filler
* Prior history of botox
* Prior liposuction
* Prior fat grafting or transfer
* Prior minimally invasive procedure
* Prior cosmetic surgeries \_\_\_\_\_\_\_\_
* Surgical implants (pins, plates, other)

Social history

* Current cigarette/nicotine (including e-cigs/vapes, hookah) use
* Packs per day or week? \_\_\_\_\_\_\_
* Years of nicotine use: \_\_\_\_\_\_\_\_\_
* Date of last nicotine use: \_\_\_\_\_\_
* Do you drink alcohol? Yes / No
* Drinks per week/month? \_\_\_\_\_\_
* Current recreational drug use
* History of recreational drug use

Lifestyle

* Exercise: Yes / No (circle)
* Frequency: \_\_\_\_\_ days per week
* Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Occupation stress factors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Diet: paleo / south beach / ketogenic / blood type diet / vegan / vegetarian / Mediterranean / raw food / commercial or fad diet / physician or nutritionist based diet (circle)

Bleeding

* Hemophilia
* Nosebleeds
* Bruise easily
* History of blood clots/DVT
* History of pulmonary embolism/PE

ENT

* Difficulty breathing through the nose (left, right, or both nostrils)
* Sleep apnea
* Mouth breathing
* Snoring
* History of or current Afrin use
* Whistling through the nose
* History of trauma to the nose
* Prior rhinoplasty
* Prior septoplasty
* Prior traumatic fracture reduction
* Have you seen an ENT?
* Allergic rhinitis, runny, stuffy nose
* Sinus infections, chronic (longer than 6 mos.) or recurrent

Eyes

* Eye pain
* Recent vision changes
* Thyroid disease
* Glaucoma
* Glasses use
* Contacts use
* Dry eyes
* Prior Lasik surgery
* Cataracts
* Blepharospasm
* Dermatochalasis
* Chemosis
* Eye problems (not listed) \_\_\_\_\_\_\_\_

Cardiac

* Hypertension/high BP
* Heart disease
* Heart murmur
* Heart palpitations
* Pacemaker
* Chest pain
* Venous insufficiency/swelling of ankles
* Spider veins
* Varicose veins
* History of heart attack
* Phlebitis
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Respiratory

* Asthma
* COPD
* Shortness of breath
* Chronic cough
* Bronchitis
* Emphysema
* History of pneumonia

Breast

* Personal history of breast cancer
* Family history of breast cancer
* Prior excision of lumps in breast or breast biopsy
* History of benign breast disease
* History of ultrasound
* History of mammogram
* Neck pain/upper back pain
* Grooving from bra straps
* Nipple discharge
* History of pregnancy (vaginal, C-section, miscarriages)
* History of breastfeeding
* Plan for children: Yes / No

GI

* Hernia
* Change in appetite
* Constipation
* Diarrhea
* Reflux
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urinary

* History of UTI
* Kidney problems
* Frequency
* Dysuria
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Musculoskeletal

* Difficulty with ambulation
* Lower back pain or lumbago
* Scoliosis
* Fibromyalgia
* Chronic pain syndrome
* Weakness/loss of muscle strength
* Frequent falls
* Myasthenia gravis
* ALS/Lou Gehrig’s disease
* Osteoarthritis
* Osteoporosis
* Herniated discs
* Other arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin

* History of excessive sun exposure
* Use of sunscreen
* History of skin cancer
* History of indoor tanning beds
* History of vitiligo
* Pruruitis
* Psoriasis
* Eczema
* Melasma
* Dry or oily skin (circle)
* Seborrhea
* Post-inflammatory hyperpigmentation
* Hypopigmentation
* Keloids
* Hair loss
* Acne
* Rosacea
* Cold sores/chickenpox (circle)

Endocrine

* Obesity
* Diabetes
* Excessive sweating
* PCOS, polycystic ovarian syndrome
* Insomnia/poor sleep habits
* Graves disease
* Hashimoto’s

Autoimmune disease

* Lupus
* Rheumatoid arthritis
* Scleroderma
* Sjogren’s
* Crohn’s
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neurologic

* Migraines
* Frequent headaches
* Seizure disorder
* Nerve compression syndrome
* Multiple sclerosis
* Stroke/CVA
* Tooth/jaw/ear pain
* History of prior head trauma

Psychiatric disorders

* Depression
* Anxiety
* Hallucinations/schizophrenia
* Body dysmorphic disorder
* Bipolar
* OCD
* Eating disorder
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Infectious

* Tuberculosis
* HIV
* Hepatitis B, C
* History of MRSA
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer

* History of cancer (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Chemotherapy
* Radiation and site:
* Surgical treatment of cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you have any medical condition not mentioned above please list:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgical History

**Please list any and all prior surgeries:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Reactions / Allergies / Latex Sensitivity**

Some patients cannot take certain medications such as penicillin because of allergic reactions. Other patients experience reactions such as nausea / vomiting from narcotic pain medications (Codeine, Morphine, Demerol, Vicodin, Percocet, etc.). Please list below regarding any known drug allergies or reactions, or sensitivities. **Please list any medications you are allergic to:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_I do not have known drug allergies, drug reactions, or latex sensitivity.

Have you had any issues with anesthesia during dental procedures? \_\_\_\_\_\_\_ If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications / Non-Prescription Medications / Dietary Supplements / Vitamins / Herbs / Minerals**

Many patients take non-prescription medications such as aspirin, anti-inflammatories (Advil, Motrin, Aleve) and other preparations that can be purchased without a prescription (dietary supplements, vitamins, “herbs”, and minerals). Many of these can have profound effects on increased risk of bleeding during and after surgery or react with prescription medications. If you currently take items in this category, please list below. Please discontinue taking all non-prescription medications, dietary supplements, vitamins, herbs, and minerals for a minimum of 10 days before and after surgery.

**Please list all prescription and non-prescription medications you currently take:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_I am not currently taking any prescription medications.

\_\_\_\_\_I am not currently taking non-prescription medications, dietary supplements, vitamins, herbs, or minerals.

#### **Smoking / Second-Hand Smoke Exposure / Nicotine Products (Patch, Gum, Nasal Spray, vape, e-liquids)** Patients who are currently smoking, use tobacco products, or nicotine products (patch, gum, vape, nasal spray, etc.) are at a greater risk for significant surgical complications of skin dying and delayed healing. Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to nicotine exposure. Additionally, smoking may have a significant negative effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine-containing products have a significantly lower risk of this type of complication. Please indicate your current status regarding these items below:

**\_\_\_\_\_\_**I am a non-smoker and do not use nicotine products. I understand the risk of second-hand smoke exposure causing surgical complications.

**\_\_\_\_\_\_**I am a smoker or use tobacco / nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.

Dominant Hand: Right:\_\_\_\_\_\_\_ Left:\_\_\_\_\_\_\_  
Pregnant?: Yes:\_\_\_\_\_\_\_\_\_ No:\_\_\_\_\_\_\_\_  
If yes, how many weeks?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When was the first day of your last menstrual cycle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**