2310 West Ray Road, Chandler, AZ 85224
22455 North Miller Road, Scottsdale, AZ 85255
Office #: (480) 686-8121 Fax#: (480) 686-8425

History and Physical

Patient Name:_____ Today's Date:_____

Date of Birth:_____/_____/_____ (MM/DD/YYYY) Age:_____

Gender: F M (please circle)

Address: _____ City/State/Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Email Address:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Primary Care Physician:_____ Phone Number:_____

Purpose of Visit/Interests (Please Circle the procedures you are interested in)

Liposuction **Fat Transfer:** (Breasts) (Buttocks) (Face) (Hands) (Calves) (Stem Cell-Enriched)

Tummy Tuck Thigh Lift Arms Lift Buttocks Lift Neck Lift Face Lift Body Lift

Breast Implants Breast Lift Breast Reduction

Fillers Featherlift Laser Scars Acne

Other:

Chief concern/complaint: (List Below)

Pertinent past medical history: (List Below)

Medication(s) causing adverse or allergic reactions: (List Below)

Previous surgeries (cosmetic or other): (List Below)

Any complications with previous surgeries? (List Below) yes no

Are you on your menstrual cycle? yes no

Where are you in your cycle? _____

Child Births: Number of C-Sections:_____ Number of Vaginal Births_____

Review of systems:

Do you smoke?	yes	no
Do you have a chronic cough?	yes	no
Heart problem, heart murmur, or irregular beat?	yes	no
Facial paralysis or Bell's Palsy?	yes	no
High blood pressure?	yes	no
Hepatitis or liver disease?	yes	no
Excessive tearing, dryness or allergic reaction to eyes?	yes	no
Asthma or COPD?	yes	no
Snoring or Obstructive Sleep Apnea?	yes	no
Have you ever had a formal sleep study?	yes	no
Do you have long periods of not breathing while asleep as noted by your partner?	yes	no
Do you use a CPAP machine?	yes	no
Do you find yourself falling asleep in the middle of the day?	yes	no
Abdominal or inguinal hernias?	yes	no
Kidney or thyroid problems?	yes	no
Previous back or nerve injury?	yes	no
History of seizure, neurological, or phychiatric problems?	yes	no
History of blood clots in legs or lungs? Leg swelling?	yes	no
History of transfusion or positive HIV test?	yes	no
Are you pregnant or possibly pregnant?	yes	no
Do you have Raynaud's disease, lupus, scleroderma, or other collagen vascular disease?	yes	no
Do you have diabetes?	yes	no
History of autoimmune disorder?	yes	no
Have you taken Accutane? If so, when?	yes	no
Any family history of complications from anesthesia?	yes	no
Have you had problems with excessive scar formation?	yes	no
Have you had problems with excessive or unexplained bleeding?	yes	no
Have you ever had MRSA or been close to someone who has?	yes	no
Do you have any questions or concerns we have not addressed?	yes	no

Referral Information

How did you hear about us? (Please Circle)

TV What Channel? _____

Internet

Magazines

Mail Inserts

Driving By

Walk In

Word of Mouth: _____

Physician Referral: _____

_____ _____

Patient Name Date

_____

Patient Signature

_____

Physician's Signature

PHYSICIAN'S PHYSICAL EXAMINATION:

Please fill out * areas only

*Patient Name: _____	*D.O.B: _____	*Date: _____
*Height:_____	*Current Weight:_____	*Maximum Weight:_____

General Appearance: _____

ENT:	WNL	ABNL	
Heart: cardiac rhythm and heart sounds:	WNL	ABNL	
Lung sounds:	WNL	ABNL	
Abdominal Exam (peri-umbilical hernia):	WNL	ABNL	
Neurological, spinal, or extremity exam:	WNL	ABNL	
Genital/ urinary examination (if indicated):	WNL	ABNL	

PATIENT'S COSMETIC CONCERNS

Facial aging overall		Abdominal/waist fat		**Other:**
Dark circles under eyes		Thigh fat		
Nose deformities		Cellulite		
Underdeveloped chin		Arm fat		
Small lips		Saggy/undersized breasts		
Sun damage		Undersized/misshaped buttocks		
Acne scars		Thin/misshaped calves		
Saggy neck/fat		Misshaped breast implants		
Droopy eyelids		Varicose/spider veins		
Hyper pigmentation		Oversized breasts		

COSMETIC PHYSICAL EXAM

FACE	+	++	+++	++++
Mid face volume				
Sun damage				
Wrinkles				
Jaw line Contour				
Chin projection				
Droopy Upper Eyelids				
Droopy Lower Eyelids				
Acne scars				
Nose shape				
Neck fat/shape				
Pigmentation				
Lips volume				

ABDOMEN	+	++	+++	++++
Fat volume				
Muscle tone				
Skin quality				
Striae				
Hernias				
Scars				
Flabbiness				
Back fat				
Waist shape				

BREASTS	*A*	*B*	*C*	*D +*
PTOSIS	None	Mild	Moderate	Severe
Abnormal	None	Scars	Masses:	Both

EXTREMITIES	+	++	+++	++++
Arms fat				
Arms Skin tone				
Inner thigh fat				
Inner thigh skin				
Outer thigh fat				
Spider veins				
Varicose veins				
Edema/sclerosis				
Buttocks				
Cellulite				

COMMENTS:

1) _____

2) _____

3) _____

4) _____

+ **: No concern or problem observed** ***++*** **: Mild or minimal problem**

+++ : **Moderate to severe concern or problem** ***++++ :*** **Extreme or obvious defec**

X _____ _____

Physician's Signature: **Date:**

Ciao Bella Medical Spa and Vein Clinic, PLC.

MEDICAL RECONCILIATION FORM

Patient Name:	D.O.B:	Date:

Have you taken any of the following medications in the past three weeks?	yes	no

Please circle the medication(s) that you are currently taking:

Tranquilizers	Diabetic Pills	Aleve	Garlic	Kava Kava
Anti-Depressants	Cholesterol Pills	Advil	Fish Oil	Ma Huang
Diuretics (Water Pills)	Birth Control Pills	Aspirin	Gingseng	St. John's Wort
Sulfa	Hormones	Ibuprofen	Ginko Biloba	Golden Seal
Diet Pills	Vitamins/Supplements	Motrin	Vitamin E	Ephedrine

Please specify bellow the names of the medications you are taking including dosage and frequency:

Medication(s)	Dosage (mg)	Frequency	Reason for taking medication

Please list bellow ANY allergies you may have:

Allergies to Medications	Reaction

Allergies to products/food	Reaction

Patient Signature	Date

Ciao Bella Medical Spa & Vein Clinic, PLC

Ciao Bella Cosmetic Surgery and Vein Clinic, PLC

Patient Name_____

Physician's surgical recommendations for optimal results:

Face:_____

_____

_____

_____

_____

Breast: _____

_____

_____

_____

_____

Body: _____

_____

_____

_____

_____

Patient's preference for alternative options: ***(optimal results may not be obtainable)***

Face:_____

_____

_____

_____

_____

Breast: _____

_____

_____

_____

Body: _____

_____

_____

_____

_____

By signing below, I acknowledge the physicians recommendations to provide an optimal result and the alternative options available.

_____

Patient Signature