UNIVERSITY OF IOWA HEALTH CARE | Aesthetic Consultants of Iowa
PLASTIC AND RECONSTRUCTIVE SURGERY

3705 River Ridge Dr. N.E.
Cedar Rapids, IA 52402
319-393-1902 ***Tel***
319-393-1867 ***Fax***
www.lookmybestnow.com or
www.uihealthcare.org/plastic-and-reconstructive-surgery

Name _____ DOB _____ Age_____ Social Security # _____

Mailing Address _____
Street / PO Box City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ If retired, previous occupation: _____

Is this a WORK or AUTO ACCIDENT related injury: ☐ YES ☐ NO Date of Injury if accident related: _____

Please list below the names and address of any Physicians you would like to receive a copy of today's evaluation (other than the physician who referred you).

Name Address *(if known)*

_____ _____

_____ _____

_____ _____

What problem are you having that brought you here today?

_____

_____

Are you currently having any pain? Please circle a number below to rate your pain:

0 1 2 3 4 5 6 7 8 9 10

No Pain ←——————————————→ Moderate Pain ←——————————————→ Sever Pain

Please list your medication below.
Include aspirin, herbals, eye drops, vitamins, and all over-the-counter medications

MEDICATION NAME	DOSE (How many milligrams?)	FREQUENCY (How many time per day?)

Please list any allergies (medication/environmental/food)

ALLERGIC TO	TYPE OF REACTION

Provider Reviewed _____

Please List any previous surgery

DATE (Approximate)	TYPE OF SURGERY	HOSPITAL

Do you smoke cigarettes? ☐ Yes ☐ No If yes, how many packs per day. _____ How many years. _____

☐ Quit smoking _____ years ago. ☐ Never smoked

Please check any other tobacco products you use: ☐ cigars ☐ pipe tobacco ☐ chew tobacco

Do you drink alcohol? ☐ Yes ☐ No If yes, what type: _____. How often: _____

Do you use any recreational or street drugs? ☐ Yes ☐ No If yes, what type: _____. How often: _____

Family Medical History

☐ Cancer ☐ COPD or Asthma ☐ Heart Disease ☐ High Blood Pressure or Stroke ☐ Kidney Disease ☐ Other

Medical History (please check all that apply to you now or in the past)

Cardiovascular:

Yes No

- ☐ ☐ Rheumatic fever
- ☐ ☐ Heart murmur
- ☐ ☐ Palpitations
- ☐ ☐ Irregular heart beat
- ☐ ☐ Chest pain
- ☐ ☐ Heart attack
- ☐ ☐ High blood pressure
- ☐ ☐ Heart failure
- ☐ ☐ High cholesterol
- ☐ ☐ Stroke / Mini stroke (TIA)
- ☐ ☐ Blood clots (DVT)
- ☐ ☐ Pulmonary emboli
- ☐ ☐ Varicose veins
- ☐ ☐ Pain in legs with walking
- ☐ ☐ Bruising / bleeding tendency
- ☐ ☐ Aneurysms

Respiratory:

Yes No

- ☐ ☐ Asthma
- ☐ ☐ Wheezing
- ☐ ☐ Emphysema
- ☐ ☐ COPD
- ☐ ☐ Chronic cough
- ☐ ☐ Tuberculosis
- ☐ ☐ Sleep apnea (stop breathing during sleep)
- ☐ ☐ Oxygen use
- ☐ ☐ Lung cancer

Gastrointestinal:

Yes No

- ☐ ☐ Stomach ulcers
- ☐ ☐ Gastric reflux / heartburn
- ☐ ☐ Hepatitis (specify A, B, C)
- ☐ ☐ Liver disease
- ☐ ☐ Blood in stool
- ☐ ☐ Black (tarry) stool
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Change in bowel movements
- ☐ ☐ Abdominal pain
- ☐ ☐ Nausea / Vomiting
- ☐ ☐ Crohns disease
- ☐ ☐ Irritable bowel syndrome
- ☐ ☐ Ulcerative colitis
- ☐ ☐ Colon cancer

Genitourinary:

Yes No

- ☐ ☐ Frequent urination
- ☐ ☐ Nighttime urinary frequency
- ☐ ☐ Burning with urination
- ☐ ☐ Blood in urine
- ☐ ☐ Lack of bladder control
- ☐ ☐ Weak urine stream
- ☐ ☐ Urinary tract infections
- ☐ ☐ Kidney stones
- ☐ ☐ Kidney failure
- ☐ ☐ Enlarged prostate
- ☐ ☐ Prostate cancer
- ☐ ☐ Bladder cancer
- ☐ ☐ Kidney cancer
- ☐ ☐ Testicular cancer
- ☐ ☐ Erectile dysfunction

Other:

Yes No

- ☐ ☐ Sexually transmitted Disease STD
- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Chronic fatigue
- ☐ ☐ Fibromyalgia
- ☐ ☐ Arthritis
- ☐ ☐ Degenerative arthritis
- ☐ ☐ Rheumatoid arthritis
- ☐ ☐ Glaucoma
- ☐ ☐ Thyroid disease
- ☐ ☐ Hyperthyroid
- ☐ ☐ Hypothyroid
- ☐ ☐ Goiter
- ☐ ☐ Thyroid cancer
- ☐ ☐ HIV / AIDS
- ☐ ☐ Diabetes
- ☐ ☐ Steroid use
- ☐ ☐ Skin Cancer
- ☐ ☐ Headaches
- ☐ ☐ Weight loss
- ☐ ☐ Food allergies

DEPRESSION / ANXIETY

Have you ever been treated for depression or anxiety?

Physician: _____

Medications: _____

Hospitalization: _____

Provider Reviewed _____

UNIVERSITY OF IOWA HEALTH CARE | Aesthetic Consultants of Iowa
PLASTIC AND RECONSTRUCTIVE SURGERY

3705 River Ridge Dr. N.E.
Cedar Rapids, IA 52402
319-393-1902 ***Tel***
319-393-1867 ***Fax***
www.lookmybestnow.com or
www.uihealthcare.org/plastic-and-reconstructive-surgery

Who Recommended This Consultation?

- ☐ Doctor _____
- ☐ Former Patient _____
- ☐ Yellow Pages
  - ☐ *Dex*
  - ☐ *Yellow Book*
  - ☐ *Other* _____
- ☐ Hospital _____
- ☐ Internet
  - ☐ www.lookmybestnow.com
  - ☐ www.uihealthcare.org/plastic-and-reconstruction-surgery
  - ☐ *Other* _____
- ☐ Friend
- ☐ Other _____

Patient Employer Insurance Information

Employer: _____

Address: _____

_____

Phone: _____

PLEASE PROVIDE CARD FOR COPYING

Policy Holder's Name _____

Policy Holder's Birth date _____

Employer _____

Spouse and/or Other Person Responsible for Account

Name _____ SS# _____
Last First MI Social Security Number

Employer _____ Work Phone _____ Birthdate _____

Other Responsible Party _____ SS# _____
Last First MI Social Security Number

Address_____ Phone _____

Patient Consent for Use of Credit/Debit Cards and Financing – Disclosure of Protected Health Information
It may become necessary to release your protected health information to financial parties, credit card entities, banks and financing companies, when requested, to facilitate your payment. Services that are preformed that are paid with a credit/debit card or financing third party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Charles Grado, MD and/or William Albright, MD (Plastic Surgical Center/Aesthetic Consultants of Iowa) to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

_____***I will not challenge such credit/debit or financing card payments once the services are provided. We encourage complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the revision policy – Although there is no surgeon's fee for most complications, you will be responsible for any charges from the hospital operating room, anesthesia, other physicians, and supplies.***

_____***I agree that this non credit card challenge agreement is irrevocable.***

Patient Signature: _____ Date: _____

Patient's Printed Name _____ Date of Birth _____

Provider Reviewed _____