526 SE 5th Avenue
Delray Beach, FL 33483
561-330-9500
5thavenueplasticsurgery.com

## WELCOME TO OUR OFFICE

*Today's visit will give you the opportunity to gather and exchange information necessary to make important decisions about your appearance. The successful outcome we both seek will be enhanced by your willingness to join us in a mutually responsible partnership. We will be with you all the way – sharing our skills and genuine concern about you and your ultimate result. Every member of our medical and support team is dedicated to optimizing your overall experience, safety, comfort and of course, anonymity.* ***KINDLY FILL OUT THE ENTIRE FORM. FRONT AND BACK.***

Date: ____/____/____ Patient Name: _____

Date of Birth: ____/____/____ Age: _____ Height: _____ Weight: _____ Gender: □ F □ M

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Cell: _____ Work: _____ Preferred Contact: □ Home □Cell □Work

Email: _____ Who Referred You? _____

Occupation: _____ □ Married □ Single Spouse: _____

Emergency Contact: _____ Telephone: _____ Relationship: _____

Do we have your permission to communicate information regarding your care/treatments via email? □Yes □ No

Would you like to receive email/SMS communications regarding our monthly specials? □Yes □ No

**My consultation today is for:** _____

### SURGICAL HISTORY (MEDICAL AND COSMETIC)

| Procedure | Date | Complications or Difficulties |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

### MEDICAL INFORMATION

Physician name/address/phone: _____

_____

Date of last physical exam: _____

Medical problems or conditions: _____

Pharmacy Name, Address and Phone:

_____

_____

### RELEASE OF INFORMATION

Who are we authorized to speak to regarding your medical information?

Name: _____ Telephone: _____ Relationship: _____

Name: _____ Telephone: _____ Relationship: _____

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| | | |
|---|---|---|
| Are you pregnant, trying to become pregnant, or any chance you might be currently? Date of last menstrual period: | ☐ Yes | ☐ No |
| Do you have any body piercings? If yes, where? | ☐ Yes | ☐ No |
| Do you have any tattoos? If yes, where? | ☐ Yes | ☐ No |
| Are you now taking any drugs or medications? If yes, please list name and frequency | ☐ Yes | ☐ No |
| Are u taking or have you ever taken any blood thinners / anticoagulation medications, steroids, hormone therapy. | ☐ Yes | ☐ No |
| Are you allergic to any medication, cream, tape, latex, make-up, etc.? If yes, please list | ☐ Yes | ☐ No |
| Have you ever received local or general anesthesia? | ☐ Yes | ☐ No |
| Did you have an adverse reaction to ANY anesthesia? If yes, please explain | ☐ Yes | ☐ No |

Do you or a family member have: (indicate who)

Heart Trouble _____ Excessive Bleeding _____
High Blood Pressure _____ Diabetes _____
Thyroid Problems _____ Psychiatric or "nerve" problems _____
Excessive Bruising _____ Excessive Scarring _____
Delayed or Poor Healing _____ Other _____

| | | |
|---|---|---|
| Do you have any history of bleeding? (Indicate which) From the Nose _____ In the Urine _____ Vomiting Blood _____ From the Rectum _____ Cough Up Blood _____ Other _____ | ☐ Yes | ☐ No |
| Do you have or have you had nasal allergies, sinus problems, asthma or hay fever? (Explain) _____ | ☐ Yes | ☐ No |
| Do you have stomach trouble? Ulcers? (Explain) _____ | ☐ Yes | ☐ No |
| Do you have or have you had chest or lung problems? (Explain) _____ | ☐ Yes | ☐ No |
| Have you ever had liver, gall bladder trouble or yellow Jaundice? (Explain) _____ | ☐ Yes | ☐ No |
| Have you been bothered by kidney or bladder problems? (Explain) _____ | ☐ Yes | ☐ No |
| Do you have frequent skin infections, irritation or rashes? (Explain) _____ | ☐ Yes | ☐ No |
| Have you ever had fever blisters, cold sores or canker sores on your face, lips or mouth or Genital Herpes (Explain) _____ | ☐ Yes | ☐ No |
| Do you often have severe headaches or dizzy spells? (Explain) _____ | ☐ Yes | ☐ No |
| Has any part of your body ever been paralyzed or numb? (Explain) _____ | ☐ Yes | ☐ No |
| Did you ever have a convulsion or seizure? (Explain) _____ | ☐ Yes | ☐ No |
| Were you ever told you had any venereal disease or AIDS? (Explain) _____ | ☐ Yes | ☐ No |
| Were you ever treated for anemia or any problems with your blood? (Explain) _____ | ☐ Yes | ☐ No |
| Do you smoke? How often? How many packs a week? | ☐ Yes | ☐ No |
| Do you drink two or more alcoholic drinks per day? | ☐ Yes | ☐ No |
| Have you ever received treatment for abuse of alcohol or drugs? (Explain) _____ | ☐ Yes | ☐ No |
| Do you often get depressed? | ☐ Yes | ☐ No |
| Have you ever received medical treatment for a nervous breakdown? (Explain) _____ | ☐ Yes | ☐ No |
| Have you ever been under the care of a psychiatrist or psychologist? (Explain) _____ | ☐ Yes | ☐ No |
| Do you have any other medical problems that have not been covered? (Explain) _____ | ☐ Yes | ☐ No |
| Do you accept the fact that every medical and surgical treatment is associated with risks and imponderables? _____ | ☐ Yes | ☐ No |

****Cancellation and No-Show Policy** – *We kindly ask that you provide us with 48 hours notice of cancellation for any appointments.* _____ Initial
***No-shows or cancellations with less than 48 hours notice will require a $100 fee to reschedule or book any future appointments.* _____ Initial

*I certify that the above information represents my complete and accurate medical history. I will not hold Dr. Tzikas or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form. I acknowledge that I have received the Notice of Privacy Practices.*

Patient/Guardian Signature: _____ Date: _____