



## Confidential Patient Health Questionnaire

Patient Name: \_\_\_\_\_ Today's Date \_\_\_\_\_

Please circle those conditions pertinent to your medical history.

### Head & Neck

- Eye disease
- Double vision
- Blurred vision
- Prior ear surgery
- Ear ache
- Hearing loss
- Dizziness
- Ringing or noise in ear
- Nasal obstruction
- Nosebleeds
- Nasal Discharge
- Altered sense of smell
- Sinusitis
- Nasal polyp[s]
- Snoring
- Excessive daytime sleepiness
- Facial pain
- Pain with chewing
- Recent dental work
- Mouth/tongue sores or ulcers
- Lumps or swellings in the head or the neck
- Skin lesions that have changed recently
- Other \_\_\_\_\_

### Respiratory System

- Hoarseness, over one week
- Chronic throat clearing
- Chronic cough
- Heartburn
- Regurgitation of food or liquids
- Coughing or spitting up blood
- Shortness of breath
- Wheezing
- Asthma
- Chronic bronchitis
- Emphysema
- Chest pain

- History of TB
- Positive TB Skin Test
- History of lung cancer
- Allergies to airborne (dust, pollens, molds, etc.)
- Other \_\_\_\_\_

### Neurological

- Headaches
- Head injury
- Numbness or tingling
- Transient black outs
- Transient loss of vision
- Seizures
- Episodes of slurred speech
- Strokes
- History of brain surgery
- Brain tumors
- Memory loss
- Anxiety or depression
- Other \_\_\_\_\_

### Cardiovascular System

- Hypertension
- Heart disease
- Angina
- Swelling of the ankles
- Heart surgery
- Angioplasty
- Pacemaker
- Shortness of breath on exertion
- Anemia or other blood disorder
- Mitro valve prolapse
- Other \_\_\_\_\_

### Endocrine

- Diabetes
- Heat or cold intolerance
- Over- or underactive thyroid
- Menstrual disorders

- Discharge from breasts
- Other \_\_\_\_\_

### Urogenital

- Difficulty or pain on urination
- Abnormal vaginal discharge or bleeding
- Frequent urination
- Blood in the urine
- Prostate problems
- Sexually transmitted diseases
- Other \_\_\_\_\_

### General

- Night Sweats
- Fevers
- Skin Diseases
- Arthritis
- Bleeding disorder
- Easy brusability
- Previous blood transfusion
- HIV infection or AIDS
- Other \_\_\_\_\_

### Gastrointestinal

- Heartburn or ulcers
- Difficult or pain on swallowing
- Chronic diarrhea or constipation
- Jaundice
- Liver disease
- Hepatitis
- Kidney disease
- Bloody stools
- Hemorrhoids
- Diverticulosis
- Gall bladder disease
- Other \_\_\_\_\_

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Please list **all** operations you have had, including cosmetic procedures. \_\_\_\_\_

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Do you smoke? Amount? \_\_\_\_\_ Do you drink alcohol? How much? \_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_

Tell me why you are here today. What are your main concerns?

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**At Pearlman Aesthetic Surgery, we enjoy taking a comprehensive approach to addressing your aesthetic concerns. In order to get the most out of our discussion today, please mark any areas of concern that you would like to cover:**

- |   |   |
|---|---|
| <input type="checkbox"/> ___ Nose shape/size                            | <input type="checkbox"/> ___ The "11's" between my brows        |
| <input type="checkbox"/> ___ Sagging face/neck                          | <input type="checkbox"/> ___ Crow's feet                        |
| <input type="checkbox"/> ___ Heavy brows                                | <input type="checkbox"/> ___ Forehead lines                     |
| <input type="checkbox"/> ___ Tired eyes/dark circles                    | <input type="checkbox"/> ___ Lines between my nose and mouth    |
| <input type="checkbox"/> ___ Loss of cheek prominence                   | <input type="checkbox"/> ___ Vertical lip lines                 |
| <input type="checkbox"/> ___ Chin prominence                            | <input type="checkbox"/> ___ Size/shape of lips                 |
| <input type="checkbox"/> ___ Excess fat/skin of the neck and/or face    | <input type="checkbox"/> ___ Hair removal                       |
| <input type="checkbox"/> ___ Skin texture/tone                          | <input type="checkbox"/> ___ Spider/leg/facial veins            |
| <input type="checkbox"/> ___ Red spots/brown spots                      | <input type="checkbox"/> ___ Eyelashes - longer, fuller, darker |
| <input type="checkbox"/> ___ Overall skin rejuvenation/skin care advice | <input type="checkbox"/> ___ Other _____                        |

Please prioritize the concerns you listed above by most concerning to least concerning by placing a number by each concern identified.

Periodically we like to reward our patients with special discounts and educate them on new, state-of-the-art procedures. Would you like to receive these announcements?  YES  NO

If YES, to what address? \_\_\_\_\_

Would you prefer to receive this information via email\*?  YES  NO

If YES, please list email address (name@example.com) \_\_\_\_\_

***\*emails are for office communication only and will not be shared or distributed***

Patient Signature \_\_\_\_\_

Today's Date \_\_\_\_\_

Physician Signature/Initials \_\_\_\_\_

Date Reviewed \_\_\_\_\_

Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please list **all** pills and medications you take regularly, as well as dose and frequency (including over-the-counter medications, E.g.; Aspirin, Advil): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list **all** allergies (medications, inhalants, foods, contact allergies): \_\_\_\_\_  
 \_\_\_\_\_

I reaffirm my allergy and medication lists above is up to date (this is for follow up visits):

Date	Initials	Date	Initials	Date	Initials



## **Patient Consent Form: Use and Disclosure of Health Information Protected under HIPAA**

Pursuant to the information contained in the Notice of Privacy Practices, I give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment, and Healthcare Operations (TPO).

I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy Practices be revised, I am aware that I may obtain a copy of the revised form by contacting the Medical Director of this facility.

I give my consent for this organization to contact me by calling my home or other designated location in order to leave a message (mechanically or with another person) or to speak to me directly regarding any matter which will help with the conduct of Treatment, Payment, and Healthcare Operations.

Further, I give my consent for the use of mail or e-mail to designated locations, including my home, to assist the organization in carrying out the described activities of Treatment, Payment, and Healthcare Operations.

I hereby consent to the use and disclosure of my PHI for the purpose of Treatment, Payment, and Healthcare Operations (TPO). This consent is good until revoked in writing, except to the extent that disclosures have been made in reliance upon my prior consent.

Services are provided without regard to sex, race, color, religion, national origin, or disability.

Dated: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Patient Signature \_\_\_\_\_

If applicable, Legal Guardian \_\_\_\_\_

**\*We are compliant with HIPAA (privacy of health information) if you desire a copy of the full notice please inquire.**



## Insurance Information\*

**\*Please check here if insurance is not being applied for visit/surgery**

**Your Name:** \_\_\_\_\_ Today's Date: \_\_\_\_\_  
                    First                    Middle                    Last

Primary Insurance:  
Name and Address of Company: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy ID #: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

Secondary Insurance:  
Name and Address of Company: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy ID #: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

Dr. Pearlman does not participate with any insurance other than Medicare. However, we may accept assignment if your insurance has out of network benefits. If applicable, our office will file insurance for you. **Office visits are payable at the time of service.**

A copy will be made of your insurance card to facilitate this process.

I authorize the release of any medical information necessary to process this claim. Signed: _____ (Patient or authorized person)  Date: _____
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I authorize payment of medical and procedure benefits to Steven Pearlman, MD.  Signed: _____ (Patient or authorized person)  Date: _____
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\*Two signatures may be necessary to process insurance claims