BESANA HEALTH & WELLNESS

Atagi Plastic Surgery and Atagi Skin Aesthetics

PATIENT HEALTH INFORMATION

Legal Name**:** _____Nickname: _____ Today's Date: _____

Date of birth: _____ Age: _____ Cell Phone: _____Message? y/n

Text appointment reminders? y/n Cell phone Carrier: _____

Street Address: _____City: _____State:_____Zip:_____
E-mail: _____

Occupation: _____ Employer: _____
How did you hear about us? _____

I am giving you permission to email me your e-newsletter. **Privacy Policy:** We respect your privacy and will not share your information. Our e-newsletter contains a one click unsubscribe, so you may leave our list anytime. _____ **Initials**

Email/ Text Communication Consent: Should the need arise to communicate with Atagi Aesthetics via text messages, please know this communication will not be encrypted; however the phones being used by employees are password protected. Please note that email/text communications should never be used for emergency communications. Email/ text communication will not be used to communicate highly sensitive medical information. Atagi Aesthetics has the right to include all correspondence in your medical record. This means that appropriate members of the staff will have access to these communications as part of your treatment. Atagi Aesthetics does not have the right to forward online communications with you to third parties except as authorized or required by law. You are responsible for taking steps to protect yourself from unauthorized use of communications, such as keeping your password confidential. Atagi Aesthetics is not responsible for breaches of confidentiality caused by you or an independent third party. _____**Initials**

I understand that payment is due in full at the time of service. I also understand that if I would like insurance reimbursement, it is my responsibility to submit a claim. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre-certify, medical record submission, or answer letters of appeal. _____ **Initials**

Emergency Contact: Name: _____Relationship: _____ Phone: _____
Primary Care Physician: _____Phone: _____
OB/GYN: _____ Phone: _____

Unless otherwise indicated, we have permission to communicate changes in your health status, to the above listed physicians? ___ Yes, may notify. ___ No, please do not notify.

GENERAL: Specific reason(s) for which you are being seen or concerns (check any that may apply):

Aesthetic Surgery

___ Face
___ Neck
___ Brows
___ Eyes
___ Lips
___ Ears

___ Small Breasts
___ Large Breasts
___ Sagging Breasts
___ Liposuction
___ Abdomen
___ Lower Extremity

___ Other: _____

Non- Surgical Services

___ Skincare / Product information
___ Facials
___ Dermaplane
___ Microdermabrasion
___ Chemical Peels
___ Laser Treatments
___ Botox
___ Ultherapy
___ Fillers
___ Bioidentical Hormones

Skin Concerns

___ Skin Discoloration / Brown spots
___ Fine lines / Deep Wrinkles
___ Acne / Rosacea
___ Lip lines / thin lips
___ Loose skin / Dry Skin / Oily Skin
___ Aging Hands
___ Facial / Body Hair
___ Facial / Leg Veins
___ Scars
___ Excessive sweating

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NAME: _____

MEDICAL HISTORY: What is your present: Height: _____ Weight:_____

Could you be pregnant? ___ Yes ___ No Are you nursing? ___ Yes ___ No Date of last menstrual period? _____

Birth Control Method: ___ Menopause ___ Tubal Ligation ___ Birth Control Pills ___ Vasectomy ___ Other _____
___ Hysterectomy with removal of ovaries. ___ Hysterectomy, uterus only. ___ Oophorectomy, removal of ovaries.

Preventative Medical Care: ___ Medical/ GYN exam within the last 12 months. ___ Mammogram within the last 12 months. ___ Bone Density test within the last 12 months. ___ Pelvic ultrasound within the last 12 months.

Have you ever had or do you have any of the following (please check and/or circle)

___ Active Infection
___ Anemia
___ Arrhythmia
___ Arthritis: Type: _____
___ Bleeding Disorders / Easy Bruising
___ Blistering Sunburns
___ Blood Clots
___ **Breast Cancer**
___ Cancer: Type(s) _____
___ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
___ Circulation Problems
___ Cold Sores / Shingles: Location: _____
___ Depression / Anxiety
___ Diabetes: Type _____
___ Eye Problems / Dry eyes / Glaucoma
___ Glasses / Contact Lens: Both Right Left
___ Endocrine / Immune Problems _____
___ **Fibrocystic Breast Disease**
___ Fibromyalgia
___ Fatigue
___ Gastrointestinal Problems / Ulcer / Hernia / Reflux / IBS
___ Genitourinary / Kidney stones / Menstrual
___ **Hashimoto's thyroiditis**
___ Headaches / Migraines
___ Heart attack
___ Heart bypass
___ Heart Condition: _____
___ Hepatitis: Type _____
___ Hernia
___ High Blood Pressure / Low Blood Pressure
___ High cholesterol
___ HIV / AIDS
___ Hormonal Imbalance / Hormonal Issues
___ Insomnia / Sleeping Problems
___ Joint Injuries
___ Metal Implants: Location(s): _____
___ Multiple Sclerosis
___ Muscle Pain / Spasms / Numbness / Tingling
___ **Leiomyoma or Endometrial Polyps.**
___ Neurological Disorder: Type: _____
___ Ovarian Cancer
___ Pacemaker / Defibrillator
___ Permanent Makeup / Tattoo(s): Location(s): _____
___ Pigmentation Disorders
___ Pneumonia
___ Psoriasis
___ Melanoma / Other Skin Cancer: Location(s): _____
___ **PCOS**
___ Psychiatric Disorder
___ Pulmonary emboli
___ Respiratory Problems / Asthma / Pneumonia / COPD
___ Scleroderma / Lupus /Autoimmune Disorder: Type: _____
___ Sensitive Teeth
___ Seizures: Last episode: _____
___ Sinus problems / Sinusitis / Difficulty breathing
___ Skin Conditions /Acne / Eczema / Psoriasis / Other: _____
___ Stroke
___ Thyroid Problems: Type: _____
___ Trouble passing urine or take Flomax or Avodart
___ Unusual Moles: Location(s): _____
___ Uterine Cancer
___ Varicose Veins
___ Other: _____

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NAME: _____

SURGICAL HISTORY: Please list **ALL** prior surgical procedures. (This includes minor procedures: tooth extractions/tonsils/appendix/gallbladder, LASIK, etc.)

Year	**Procedure**	**Surgeon**	**Complications**

MEDICATIONS: - Please list **ALL** medications including **herbs, dietary supplements, or weight reduction** products.

Medication	Dose	Why?	Medication	Dose	Why?

Do you take aspirin or ibuprofen products? ☐ **Yes** ☐ **No**

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

SOCIAL HISTORY:

☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Children Age(s): _____

Do you smoke? Or Have you ever smoked? ☐ **Yes** ☐ **No**
If yes, please indicate and circle appropriate reply:

_____ Cig's or Packs / Day_____ x Years Quit _____ weeks/months/years ago

Do you drink alcohol? ____ times/Day ____ times/Week ____ Rarely _____ Never

Do you drink caffeinated beverages? ☐ **Yes** ☐ **No** If yes: _____/Day

ALLERGIES & SENSITIVITIES:

Medication Allergies or Sensitivities? ☐ **Yes** ☐ **No**

If so, please indicate drug and circle reaction(s).

Medication(s)	**Reaction**
_____	Rash/Hives/Anaphylaxis/Swelling/Nausea/Vomiting/Other_____
_____	Rash/Hives/Anaphylaxis/Swelling/Nausea/Vomiting/Other_____

Environmental or Food Allergies? ☐ **Yes** ☐ **No** Latex Allergies? ☐ **Yes** ☐ **No**

Tape or Adhesive Sensitivities? ☐ **Yes** ☐ **No** **Type?** _____

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NAME: _____

ANESTHESIA HISTORY:

- ___ None
- ___ General Anesthesia: Nausea/Vomiting/Slow awakening/Difficult intubation/other _____
- ___ IV Sedation: Nausea/Vomiting/Slow awakening/other _____
- ___ Epidural/Spinal: Nausea/Vomiting/Insufficient/Bleeding/Headache/Other _____
- ___ Block: Insufficient /Prolonged/Systemic reaction/other _____
- ___ Local: Insufficient block/Heart palpitations/Systemic reaction/other _____

FAMILY HISTORY:

Do you have a family history of:			Relationship	Problem
Heart problems	___ **Yes**	___ **No**		
Diabetes	___ **Yes**	___ **No**		
Breast cancer	___ **Yes**	___ **No**		
Other cancers	___ **Yes**	___ **No**		
Thyroid	___ **Yes**	___ **No**		
Stroke	___ **Yes**	___ **No**		
Bleeding problems	___ **Yes**	___ **No**		
Anesthesia problems	___ **Yes**	___ **No**		
Other problems	___ **Yes**	___ **No**		

SKINCARE:

Please indicate your current skincare routine and products: _____
Please list any products or treatments that irritate your skin: _____

Have you had any of the following facial procedure preformed?

Facial	___ **Yes**	___ **No**	Oxygen infusion facial	___ **Yes**	___ **No**
Chemical/ Enzyme Peel	___ **Yes**	___ **No**	Microdermabrasions	___ **Yes**	___ **No**
Dermaplanes	___ **Yes**	___ **No**	Laser treatments	___ **Yes**	___ **No**

Are you currently under the care of an Aesthetician? ___ **Yes** ___ **No**

Have you ever used Accutane? ___ **Yes** ___ **No**

Would you like to be color matched with our Jane Iredale skin care makeup? ___ **Yes** ___ **No**

Patient Signature: _____ Date: _____
Atagi Aesthetics representative: _____ Date: _____

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Name: _____ **Date:** _____

Symptom *(please check mark)*	**Never**	**Mild**	**Moderate**	**Severe**
Acne				
Anxiety/ Tension/ Nervousness				
Cold all the time				
Decreased sex drive/libido				
Depressive mood				
Difficult to climax/ perform sexually				
Dry and wrinkled Skin				
Exhaustion/ Feeling burned out				
Hair loss (beard, scalp, body)				
Joint pain				
Memory Loss				
Mental confusion				
Migraine/severe headaches				
Mood changes/Irritability				
Sleep problems/ Increased need for sleep				
Swelling all over the body				
Women Only				
Bloating				
Breast tenderness				
Facial hair				
Hot flashes				
Night sweats				
Vaginal dryness				
Men Only				
Breast Development				
Decreased morning erections				
Feeling you have passed your peak				
No Results from E.D. Medications				

Other symptoms that concern you:

BESANA Health & Wellness
303.327.7300 | BesanaWellness.com
10099 RidgeGate Parkway, Suite 440,
Lone Tree, CO 80124

Atagi Plastic Surgery
303.327.7300 | AtagiMD.com
10099 RidgeGate Parkway, Suite 430
Lone Tree, CO 80124