BESANA HEALTH & WELLNESS

Atagi Plastic Surgery and Atagi Skin Aesthetics

MALE 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: _____

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:_____

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**

Patient Signature: _____ Date: _____

Atagi Aesthetics representative: _____ Date: _____

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

Atagi Plastic Surgery
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10099 RidgeGate Parkway, Suite 430
Lone Tree, CO 80124

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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:

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