***Board Certified***
*Facial Plastic and Cosmetic Surgery ~ Otolaryngology ~ Audiology ~ Allergy*
*2501 E. Chapman Ave., Ste. 401* *1325 N. Rose Dr., Ste. 206*
*Orange, Ca. 92869* *Placentia, Ca. 92870*
*Phone 714 628-1313 Fax 714 628-1319*
*www.cohendoc.com*

# PATIENT HEALTH HISTORY

Date: _____ Referred By: _____ Chart #: _____

Patient Name: _____ Date of Birth: _____

Address:

_____

City: _____ State: _____ Zip: _____Country: _____

Home Ph#: _____ Cell Ph#: _____

E-mail: _____ Gender: (circle one) *Female* *Male*

Marital Status: (circle one) *Single* *Married* *Separated* *Divorced* *Widow* Occupation: _____

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Please check the procedure(s) in which you are interested.

| | | | |
|---|---|---|---|
| ❒ Body Liposuction | ❒ Otoplasty (ear pinning) | ❒ Juvederm™ Injectable | ❒ Laser Hair Removal |
| ❒ Facial Liposuction | ❒ Torn Earlobe Repair | ❒ Chemical Peels | ❒ IPL |
| ❒ Blepharoplasty (eyes) | ❒ Rhinoplasty (nose) | ❒ TCA Peels | ❒ Facials |
| ❒ Brow Lift | ❒ Sculptra™ Injectable | ❒ CO2 Laser Resurfacing | ❒ Skin Care |
| ❒ Mini Face Lift | ❒ Restylane® Injectable | ❒ Thermage® | ❒ Other:_____ |
| ❒ Full Face Lift | ❒ Botox Cosmetic® Injectable | ❒ Laser Vein Removal | _____ |

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## Aesthetic History

When did you first consider cosmetic procedures?

_____

Have you consulted with another doctor? ❒ Yes ❒ No

Have you had any previous cosmetic treatments, plastic or reconstructive surgery? ❒ Yes ❒ No

What type of treatment/procedure? _____

Performed by _____ Date _____

Has any family member or close friend had any cosmetic treatment, plastic or reconstructive surgery? ❒ Yes ❒ No

What type of treatment/procedure? _____

Performed by _____ Date _____

Do you feel he or she could have obtained better results? ❒ Yes ❒ No

If yes, please explain _____

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## Medical History

Are you currently taking any medications? ❒ Yes ❒ No

If yes, please list all medications _____

_____

Are you currently taking aspirin, ibuprofen, minerals, herb, nutritional supplements, birth control pills or sexual performance drugs? ❒ Yes ❒ No

If yes, please list _____

_____

Do you have any allergies or sensitivities? ❒ Yes ❒ No

If yes, please explain _____

Have you ever had local anesthesia (Novocain, Xylocaine, etc) by a dentist or doctor? ❒ Yes ❒ No

Have you ever experienced an adverse reaction to anesthesia? ❒ Yes ❒ No

If yes, please explain _____

Do you have a history of bleeding? ❒ Yes ❒ No

❒ Bleeding from the nose ❒ Blood in urine ❒ Vomiting blood ❒ Bleeding from dental procedures

❒ Bleeding from the rectum ❒ Coughing up blood ❒ Other:_____

If yes, please explain _____

Have you ever had any medical surgeries? ❒ Yes ❒ No

Type of surgery _____ Date _____

Type of surgery _____ Date _____

Did you experience any complications? ❒ Yes ❒ No

If yes, please explain _____

Please check ***all*** that apply to you currently or in the past:

| | | | |
|---|---|---|---|
| Allergies | ❒ Yes ❒ No | High / Low Blood Pressure | ❒ Yes ❒ No |
| Hay Fever | ❒ Yes ❒ No | Kidney Disease | ❒ Yes ❒ No |
| Nasal Allergies | ❒ Yes ❒ No | Bladder Disease | ❒ Yes ❒ No |
| Asthma | ❒ Yes ❒ No | Arthritis | ❒ Yes ❒ No |
| Vision / Eyes | ❒ Yes ❒ No | Decreased circulation (fingers/toes) | ❒ Yes ❒ No |
| Chest Pains | ❒ Yes ❒ No | Skin Infections | ❒ Yes ❒ No |
| Stomach Ulcers | ❒ Yes ❒ No | Skin Irritations | ❒ Yes ❒ No |
| Lung Disease | ❒ Yes ❒ No | Skin Rashes | ❒ Yes ❒ No |
| Liver Disease | ❒ Yes ❒ No | Herpes | ❒ Yes ❒ No |
| Gall Bladder Disease | ❒ Yes ❒ No | HIV/Aids | ❒ Yes ❒ No |
| Yellow Jaundice | ❒ Yes ❒ No | Sexually Transmitted Disease | ❒ Yes ❒ No |
| Severe Headaches | ❒ Yes ❒ No | Seizures | ❒ Yes ❒ No |
| Dizzy Spells | ❒ Yes ❒ No | Depression | ❒ Yes ❒ No |
| Paralysis/Numbness | ❒ Yes ❒ No | Mitral Valve Prolapsed | ❒ Yes ❒ No |
| Bruise Easily | ❒ Yes ❒ No | Autoimmune Disease (Lupus, MS) | ❒ Yes ❒ No |

If you answered yes to any of the above, please explain and list medications used to treat the condition _____

_____

_____

Do you ***or*** any family members have the following (please indicate relationship)?

| | | |
|---|---|---|
| Heart trouble | ❒ Yes ❒ No | Relationship_____ |
| Excessive bleeding | ❒ Yes ❒ No | Relationship_____ |
| Diabetes | ❒ Yes ❒ No | Relationship_____ |
| Thyroid problems | ❒ Yes ❒ No | Relationship_____ |
| Excessive bruising | ❒ Yes ❒ No | Relationship_____ |
| Unfavorable/wide scarring | ❒ Yes ❒ No | Relationship_____ |
| Delayed or poor healing | ❒ Yes ❒ No | Relationship_____ |
| Psychiatric or nerve problems | ❒ Yes ❒ No | Relationship_____ |
| Arthritis | ❒ Yes ❒ No | Relationship_____ |
| High blood pressure | ❒ Yes ❒ No | Relationship_____ |

Low blood pressure ❒ Yes ❒ No Relationship_____

Depression ❒ Yes ❒ No Relationship_____

Other _____ ❒ Yes ❒ No Relationship_____

❒ ***Women Only***:

Is there a history of breast cancer in your family? ❒ Yes ❒ No

If yes, please specify _____

Is your menstrual cycle often irregular? ❒ Yes ❒ No Do you have heavy menstrual periods? ❒ Yes ❒ No

When was your last period? _____ How many tampons/pads do you use per day? _____

How many days do your periods last? _____ Are you currently or trying to get pregnant? ❒ Yes ❒ No

Do you have a history of gynecological problems? ❒ Yes ❒ No When was your last physical examination? _____

❒ ***Men Only***:

Have you ever had prostate problems? ❒ Yes ❒ No

If yes, please specify

_____

Do you use sexual performance drugs such as Viagra, Levitra, Cialis, etc.? ❒ Yes ❒ No

Are you frequently sick or ill? ❒ Yes ❒ No

Have you ever taken hormone or thyroid medications? ❒ Yes ❒ No

Are you double jointed? ❒ Yes ❒ No

Can you touch your tongue to your nose or your thumb to your forearm? ❒ Yes ❒ No

Do you have a tendency to faint or pass out? ❒ Yes ❒ No

Do you drink more than 6 cups of coffee per day? ❒ Yes ❒ No

Do you smoke cigarettes? ❒ Yes ❒ No

If yes, please provide the approximate daily consumption _____

Do you normally have more than 2 drinks of alcohol per day? ❒ Yes ❒ No

Have you ever been under the care of a psychologist or psychiatrist? ❒ Yes ❒ No

If yes, please explain _____

Do you desire improvement in function as well as aesthetic? ❒ Yes ❒ No

If yes, please explain

_____

Do you understand that medical and surgical treatments cannot promise or guarantee a good outcome?

❒ Yes ❒ No

Do you understand that all risks and complications cannot be prevented when a surgical procedure is performed?

❒ Yes ❒ No

.

Patient's signature _____ Date _____

Physician's signature _____ Date _____

Reviewed by _____ Date _____

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Emergency Contact _____ Relationship _____

Home #:_____ Cell #: _____ Work #: _____

Family Physician _____ Phone #: _____

City _____ State _____ Country _____

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## NOTICE OF PRIVACY PRACTICES

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

### OUR LEGAL DUTY

**Law Requires us to:**

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

**We Have the Right to:**

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

**Notice of Change to Privacy Practices:**

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

### USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

**FOR TREATMENT:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

**FOR PAYMENT:** We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

**FOR HEALTH CARE OPERATIONS:** We may use and disclose your medical information to our health care operations to support the business activities of our practice. We may use medical information about you to review and evaluate our treatment and services or to evaluate our staff`s performance while caring for you.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information about you.

**ADDITIONAL USES AND DISCLOSURES:**

**As required by law.** We may use and disclose your health information when required to by federal, state, or local law.

**Public Health Activities:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

**Worker`s Compensation:** We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

**YOUR INDIVIDUAL RIGHTS**

**You Have a Right to:**

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. If you request copies, we may charge you for the costs of copying, mailing, or other supplies used in fulfilling your request.

2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions. You must request in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years. You are entitled to one list per year without charge. There is a charge for additional lists within the 12 month period.

3. Request that we place additional restrictions on our use or disclosure of your medical information. You may request we do not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

4. Request that we communicate with you about your medical information by different means or to different locations. You may request that we call you only at your work number, or by mail at a special address. Your request must be in writing.

5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

**Complaints:** If you believe we may have violated your privacy rights, you may file a complaint in writing within 180 days of the suspected violation. You may file this directly with the Secretary of Health and Human Services, or with the Privacy Officer c/o William C. Cohen, D.O., 2501 E. Chapman Ave., Ste 401, Orange, Ca. 92869

**PRIVACY PRACTICES ACKNOWLEDGEMENT**

By signing this form, you acknowledge receipt of the **Notice of Privacy Practices** of **William C. Cohen, D.O., F.A.O.C.O.**

Our **Notice of Privacy Practices** provides information about how we may use and disclose your protected health information.

Our **Notice of Privacy Practices** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at 714 628-1313.

I have received the **Notice of Privacy Practices,** and I have reviewed it.

Name_____
(patient/parent/conservator/guardian)

Signature_____

Date_____