1614 DUNDAS ST. EAST, SUITE #101 WHITBY, ON L1N 8Y8
905-438-9000 www.drkaraplasticsurgery.com

NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

HOME PHONE#:_____ CELL# _____ WORK#_____

E-MAIL ADDRESS: _____ NEWSLETTER: YES / NO

HOW DID YOU HEAR ABOUT US? _____

SEX: M ____ F _____ AGE: _____DATE OF BIRTH_____

HEALTH CARD # _____VERSION CODE: _____EX DATE_____

FAMILY DOCTOR_____PHONE # _____

EMERGENCY CONTACT_____PHONE#_____

EMERGENCY CONTACT RELATIONSHIP: _____ ARE YOU A CANADIAN CITIZEN? YES / NO

PLEASE INDICATED WHAT SURGICAL PROCEDURES YOU ARE INTERESTED IN:

☐ABDOMINOPLASTY (TUMMY TUCK)
☐LIPOSUCTION
☐BREAST AUGMENTATION (24 HOUR RECOVERY)
☐BREAST LIFT OR REDUCTION
☐BREAST REVISION/IMPLANT REPLACEMENT
☐BLEPHAROPLASTY (EYELID SURGERY)
☐GYNECOMASTIA (MALE BREAST REDUCTION)
☐LOWER BODY LIFT (BELT)
☐FACELIFT/NECK LIFT
☐ARM LIFT
☐THIGH LIFT
☐FAT TRANSFER
☐OTHER: _____

IF ANY, PLEASE LIST ALL SURGICAL PROCEDURES YOU HAVE EVER UNDERGONE AND WHEN:

_____

_____

WHICH AREAS DO YOU WANT TO IMPROVE?

☐WRINKLES
☐AGE/BROWN SPOTS
☐SPIDER VEINS
☐SPIDER VEINS ON NOSE AND/OR CHEEKS
☐ROSACEA
☐ENLARGED PORES
☐RAISED MOLES OR OTHER LESIONS
☐AGING SKIN
☐SAGGING SKIN
☐DULL/GREY PALLOR (PALE SKIN)
☐AGING AREA AROUND EYES
☐AGING AREA AROUND MOUTH
☐SUN DAMAGE ON NECK/DECOLLETAGE (CHEST)

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☐SUN DAMAGE ON BACKS OF HANDS/ARMS/LEGS
☐LOCALIZED FAT DEPOSITS
☐SCARS
☐ALL OF THE ABOVE

WHICH TREATMENTS ARE YOU INTERESTED IN?

☐LASER SKIN IMPROVEMENT - BEST RESULT WITH NO DOWNTIME
☐LASER SKIN IMPROVEMENT - BEST RESULT WITH MINIMAL DOWNTIME
☐LASER SKIN IMPROVEMENT - BEST RESULT POSSIBLE
☐ACNE/ROSACEA MANAGEMENT
☐PRESCRIPTION SKIN CARE PRODUCTS/SKIN CARE
☐BOTOX
☐DERMAL FILLERS
☐COOLSCULPTING
☐SPIDER VEIN TREATMENT
☐BOTOX TO REDUCE SWEATING AND/OR MIGRAINES
☐MEDICAL GRADE FACIAL
☐IPL (INTENSE PULSED LIGHT THERAPY)/BBL
☐LASER HAIR REMOVAL
☐LATISSE
☐ALL OF THE ABOVE

COSMETIC TREATMENT HISTORY:

☐ YES ☐NO – HAVE YOU EVER USED ACUTANE? IF YES, WHEN: _____

COMPLICATIONS (IF ANY) _____

☐ YES ☐NO – PREVIOUS LASER OR IPL/BBL? IF YES, WHEN: _____

TYPE OF LASER (IF KNOWN): _____

COMPLICATIONS (IF ANY) _____

☐ YES ☐NO – PREVIOUS DERMAL FILLERS? IF YES, WHEN: _____

TYPE OF FILLER (IF KNOWN): _____

COMPLICATIONS (IF ANY) _____

☐ YES ☐NO – PREVIOUS BOTOX (OR OTHER NEUROMODULATORS)? IF YES, WHEN: _____

TYPE OF NEUROMODULATORS (IF KNOWN): _____

COMPLICATIONS (IF ANY) _____

☐ YES ☐NO – OTHER COSMETIC TREATMENTS? IF YES, WHEN: _____

TYPE (PEEL, MICRODERM, SKIN CARE, ETC): _____

COMPLICATIONS (IF ANY): _____

FOR WOMEN ONLY

☐ YES ☐NO - ARE YOU SEXUALLY ACTIVE?
☐ YES ☐NO - ARE YOU PREGNANT OR BREAST-FEEDING?
☐ YES ☐NO - ARE YOU CURRENTLY USING BIRTH CONTROL?

HEALTH DISCLOSURE STATEMENT

ALLERGIES AND SENSITIVITIES IS THERE ANY HISTORY OF SKIN REACTION OR OTHER ILLNESS FOLLOWING CONTACT WITH:

☐ YES ☐NO - PENICILLIN, SULFA OR OTHER ANTIBIOTIC?
☐ YES ☐NO - MORPHINE, CODEINE, DEMEROL OR NARCOTIC?

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☐ YES ☐ NO - NOVOCAIN, LIDOCAINE OR LOCAL ANESTHETICS?
☐ YES ☐ NO - TETANUS TOXOID OR SERUMS?
☐ YES ☐ NO - ADHESIVE TAPE?
☐ YES ☐ NO - IODINE, BETADINE, CHLORHEXIDINE OR PHISOPHEX ?
☐ YES ☐ NO - TINCTURE OF BENZOIN?
☐ YES ☐ NO - LATEX RUBBER?
☐ YES ☐ NO - OTHER DRUG MEDICINE OF OTHER SUBSTANCE?
(IF YES LIST HERE) _____

DO YOU CURRENTLY TAKE ANY OF THE FOLLOWING DRUGS AND MEDICINES OR HAVE YOU WITHIN THE LAST 6 MONTHS?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - CORTISONE, PREDNISONE OR ACTH?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - DIURETICS OR WATER PILLS?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - BLOOD PRESSURE MEDICATION?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - STEROIDS OR BODY BUILDING DRUGS?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - SEIZURE MEDICATION?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - INSULIN OR DIABETES MEDICATION?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - HEADACHE OR MIGRAINE MEDICATIONS?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - ASTHMA MEDICATION?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - PHEN-PHEN OR REDUX?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - BIRTH CONTROL PILLS?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - ANTIBIOTICS?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - HEART MEDICATION?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - ANTICOAGULANTS OR BLOOD THINNERS?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - PAIN PILLS?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - APPETITE SUPPRESSANTS OR DIET PILLS?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - SEDATIVES, TRANQUILIZERS OR SLEEPING PILLS?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - ANTIDEPRESSANTS, ANTIPSYCHOTICS OR NERVE PILLS?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - RECREATIONAL OR ILLEGAL DRUGS?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - HOMEOPATHIC OR HERBAL MEDICINES?
☐ CURRENTLY ☐ IN THE LAST 6 MONTHS ☐ NO - OTHER DRUGS OR MEDICATIONS USED?
(IF YES TO ANY, PLEASE LIST HERE) _____
_____
PLEASE LIST ANY DIETARY SUPPLEMENTS, HOMEOPATHIC MEDICATION OR VITAMINS YOU TAKE: _____
_____
_____
_____

IMPORTANT MEDICAL CONDITIONS
HAVE YOU EVER HAD OR RECEIVED TREATMENT FOR ANY OF THE FOLLOWING?
☐ YES ☐ NO - HEPATITIS (HEP. B., C. ETC.) LIVER DISEASE?
☐ YES ☐ NO - HIV OR AIDS?
☐ YES ☐ NO - ASTHMA? TB?
☐ YES ☐ NO - PULMONARY EMBOLUS?
☐ YES ☐ NO - HIGH BLOOD PRESSURE?
☐ YES ☐ NO - HEART ATTACK, PALPITATIONS?
☐ YES ☐ NO - CONGENITAL HEART DISEASE?
☐ YES ☐ NO - CHEST PAIN?
☐ YES ☐ NO - DIZZINESS?
☐ YES ☐ NO - PACEMAKER?

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☐ YES ☐ NO - ARTIFICIAL HEART VALVE?
☐ YES ☐ NO - MITRAL VALVE PROLAPSE?
☐ YES ☐ NO - FAINTING?
☐ YES ☐ NO - GASTROESOPHAGEAL REFLUX?
☐ YES ☐ NO - CHRONIC FATIGUE SYNDROME?
☐ YES ☐ NO - PSYCHOLOGICAL OR EMOTIONAL PROBLEMS?
☐ YES ☐ NO - SHINGLES, COLD SORES, FEVER BLISTERS OR ORAL HERPES?
☐ YES ☐ NO - STOMACH ULCERS?
☐ YES ☐ NO - CHRONIC OR RECENT COUGH?
☐ YES ☐ NO - PHLEBITIS, BLOOD CLOTS OR VARICOSE VEINS?
☐ YES ☐ NO - BLOOD TRANSFUSIONS?
☐ YES ☐ NO - ADVERSE OR UNUSUAL REACTION TO ANESTHESIA?
☐ YES ☐ NO - ABNORMAL HEALING OR POOR SCAR FORMATION?
☐ YES ☐ NO - EDEMA, PERSISTENT OR UNUSUAL SWELLING?

IMPORTANT MEDICAL CONDITIONS

HAVE YOU EVER HAD OR RECEIVED TREATMENT FOR ANY OF THE FOLLOWING? (CONTINUED)

☐ YES ☐ NO - VENEREAL DISEASE?
☐ YES ☐ NO - ANXIETY OR “PANIC ATTACKS”?
☐ YES ☐ NO - MIGRAINES, HEADACHES?
☐ YES ☐ NO - ANEMIA OR BLOOD DISORDER?
☐ YES ☐ NO - ABNORMAL BLEEDING?
☐ YES ☐ NO - EASY BRUISING?
☐ YES ☐ NO - ALCOHOLISM?
☐ YES ☐ NO - DRUG ADDICTION?
☐ YES ☐ NO - KIDNEY FAILURE, OR ANY OTHER KIDNEY DISEASE?
☐ YES ☐ NO - GLAUCOMA?
☐ YES ☐ NO - STIFF NECK?
☐ YES ☐ NO - BACK PROBLEMS? ARTIFICIAL JOINT?
☐ YES ☐ NO - SCARS/KELOIDS?
☐ YES ☐ NO - DIABETES?
☐ YES ☐ NO - THYROID PROBLEM OR GRAVES DISEASE?
☐ YES ☐ NO - CHRONIC HEAD PAIN?
☐ YES ☐ NO - SEIZURES?
☐ YES ☐ NO - STROKE?
☐ YES ☐ NO - BELL’S PALSY OR NEUROLOGICAL PROBLEMS?
☐ YES ☐ NO - AUTOIMMUNE DISEASE? LUPUS?
☐ YES ☐ NO - BIPOLAR OR MANIC-DEPRESSIVE ILLNESS?
☐ YES ☐ NO - PERSONALITY DISORDERS?
☐ YES ☐ NO - CURRENTLY IN THERAPY OR COUNSELLING?
☐ YES ☐ NO - SEVERE ALLERGY ATTACK?
☐ YES ☐ NO - SLEEP APNEA?
☐ YES ☐ NO - SLEEP DISORDER?
☐ YES ☐ NO - X-RAY TREATMENTS OR RADIATION THERAPY?
☐ YES ☐ NO - BODY DYSMORPHIC DISORDER?
☐ YES ☐ NO - EATING DISORDERS?

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☐ YES ☐ NO - OTHER MEDICAL CONDITION (IF YES, LIST HERE)

_____

_____

MEDICATIONS THAT MAY CAUSE BLEEDING, DO YOU TAKE ANY OF THE FOLLOWING ON A REGULAR BASIS:

☐ YES ☐ NO - ASPIRIN OR ASPIRIN CONTAINING MEDICATIONS?
☐ YES ☐ NO - IBUPROFEN (MOTRIN, ADVIL, NURPIN)?
☐ YES ☐ NO - KETOPROFEN (ALEEVE)?
☐ YES ☐ NO - VITAMIN E? (EXCLUDING THAT IN A MULTIVITAMIN)
☐ YES ☐ NO - ANTI-INFLAMMATORIES OR MUSCLE RELAXANTS?
☐ YES ☐ NO – HAVE YOU OR ANY BLOOD RELATIVE HAD ANESTHESIA COMPLICATIONS OF ANY KIND?

SMOKING

☐ YES ☐ NO - DO YOU CURRENTLY SMOKE, OR HAVE YOU SMOKED IN THE PAST? (OR NICOTINE-CONTAINING PRODCUTS)
IF QUIT, NUMBER OF YEARS QUIT _____
IF YES:
AVERAGE NUMBERS OF PACKS SMOKED PER DAY _____
APPROXIMATE NUMBER OF TOTAL YEARS SMOKED _____

DENTAL

☐ YES ☐ NO - DO YOU HAVE DENTURES, VENEERS, CAPPED TEETH OR ANY LOOSE DENTAL DEVICES?

STATEMENT OF INFORMATION ACCURACY

I UNDERSTAND THAT THE INFORMATION ON THESE FORMS IS ESSENTIAL TO DETERMINE MY MEDICAL AND COSMETIC NEEDS AND THE PROVISION OF TREATMENT. I UNDERSTAND THAT IF ANY CHANGES OCCUR IN MY MEDICAL HISTORY/HEALTH I WILL REPORT IT TO THE OFFICE AS SOON AS POSSIBLE. I HAVE READ AND UNDERSTAND THE ABOVE MEDICAL QUESTIONNAIRE. I ACKNOWLEDGE THAT ALL ANSWERS HAVE BEEN RECORDED TRUTHFULLY AND WILL NOT HOLD ANY STAFF MEMBER RESPONSIBLE FOR ANY ERRORS AND OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM.

PLEASE BE ADVISED THAT THE OFFICE IS EQUIPPED WITH AUDIO RECORDING – ALL PHONE CALLS IN AND OUT OF THE OFFICE ARE ALSO RECORDED FOR QUALITY ASSURANCE AND TRAINING PURPOSES.

HERE AT DR.KARA MEDICINE PROFESSIONAL CORPORATION WE PRIDE OURSELVES ON PATIENT CARE AND REQUEST A MUTUAL RESPECT TO STAFF AND PATIENTS. ANY AGGRESSIVE LANGUAGE OR BEHAVIOUR WILL RESULT IN IMMEDIATE TERMINATION OF PATIENT CARE.

_____ _____ _____
PATIENT SIGNATURE PRINTED NAME DATE

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I UNDERSTAND THAT AS PART OF MY HEALTHCARE, THIS ORGANIZATION CREATES AND MAINTAINS HEALTH RECORDS DESCRIBING MY HEALTH HISTORY, SYMPTOMS, EXAMINATION AND TEST RESULTS, DIAGNOSES, TREATMENT, AND ANY PLANS FOR FUTURE CARE OR TREATMENT. I UNDERSTAND THAT THIS INFORMATION SERVES AS:

- A BASIS FOR PLANNING MY CARE AND TREATMENT
- A MEANS OF COMMUNICATION AMONG ANY HEALTH PROFESSIONALS WHO CONTRIBUTE TO MY CARE
- A SOURCE OF INFORMATION FOR APPLYING MY DIAGNOSIS AND MEDICAL INFORMATION TO MY BILL
- A MEANS BY WHICH A THIRD-PARTY PAYER CAN VERIFY THAT SERVICES BILLED WERE ACTUALLY PROVIDED
- A TOOL FOR ROUTINE HEALTHCARE OPERATIONS SUCH AS ASSESSING QUALITY AND REVIEWING THE COMPETENCE OF HEALTHCARE PROFESSIONALS

I UNDERSTAND THAT I HAVE THE RIGHT TO OBJECT TO THE USE OF MY HEALTH INFORMATION FOR DIRECTORY PURPOSES. I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST RESTRICTIONS AS TO HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS AND THAT THE ORGANIZATION IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS REQUESTED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING, EXCEPT TO THE EXTENT THAT THE ORGANIZATION HAS ALREADY TAKEN ACTION IN RELIANCE THEREON.

.

I REQUEST THE FOLLOWING RESTRICTIONS TO THE USE OR DISCLOSURE OF MY HEALTH INFORMATION: _____

_____

_____

_____-

_____

_____	_____	_____
PATIENT SIGNATURE	PRINTED NAME	DATE
_____	_____	_____
WITNESS SIGNATURE	PRINTED NAME	DATE
_____	_____	_____
DOCTOR SIGNATURE	PRINTED NAME	DATE