



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