Simply Sculpt
REFINE RESHAPE REVEAL

MEDICAL HISTORY AND PHYSICAL

Name _____ Age _____

Sex _____ D.O.B. _____ Phone number _____

Address _____ Email _____

City _____ State _____ Zip _____

Employer _____ Job Title/Occupation _____

Emergency Contact _____ Relationship _____

Phone _____ Will they be your driver for the procedure?____

Are we allowed to discuss medical information with them? _____

Today's Date _____ How were you referred to us? _____

Pharmacy Name _____ Pharmacy Phone _____

Do you have any allergies? Please list name and type of reaction

Allergen	Item	Reaction
Medication		
Environmental		
Foods		
Other		

Do you have any skin sensitivities/allergies? YES or NO If yes, to what? _____

Do you form thick or raised scars (keloids) from cuts or burns? YES or NO

Do you have hyperpigmentation (darkening of skin) or hypopigmentation (lightening of skin) after physical trauma? YES or NO

Are you pregnant or trying to become pregnant? YES or NO Are you nursing? YES or NO

Are you on birth control? YES or NO If so, what kind? _____

Have you ever had a reaction to Lidocaine? YES or NO

Have you ever had a reaction to Epinephrine? YES or NO

Do you have any sensitivities/allergies to latex, foam tape or paper tape? YES or NO

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Past Medical History

Do you have or have you ever had any other following conditions?

Condition	Check if apply	How Treated?
Anemia		
Asthma		
Autoimmune disorder		
Bleeding/Clotting Disorder		
Blood Clots		
Cancer		
COPD		
Crohn's Disease		
Circulatory Issues		
Cardiac Issues (ex. Afib, heart attack, stents, arrhythmias, heart infection, transplant, etc)		
Diabetes (insulin or non-insulin dependent)		
Emphysema		
Epilepsy/Seizures		
Fainting/Syncope		
Fibromyalgia		
Gallbladder		
GI bleed		
Glaucoma		
GI issues (ex. IBS, GERD, celiac)		
Gout		
Heart Disease		
Heartburn/Reflux		
Hepatitis A, B, or C		
High Cholesterol		
HIV/AIDS		
Hypertension/hypotension		
Kidney Disease		
Liver disease		
Migraines		
Mental Illness (ex. Depression, anxiety, bipolar)		
Osteoarthritis		
Osteoporosis		
Pneumonia		

Parkinson's		
Prosthetic or artificial joint		
Radiation or chemotherapy		
Rheumatoid Arthritis		
Stroke/TIAs		
Sleep Apnea		
Stomach Ulcers		
Sickle Cell		
STIs		
TB		
Thyroid (hypo or hyper)		
Ulcerative Colitis		
Do you have any implantable devices? (ex. Pacemaker,		
Wear glasses, contacts, dentures		

Are you currently experiencing any of the following? Please **CIRCLE** those that apply

- General: Weight loss, Weight gain, Fever, Night sweats, Fatigue
- ENT: Headaches, difficulty swallowing, nosebleeds
- Cardiovascular: chest pain, fainting, palpitations
- Respiratory: Shortness of breath, wheezing, coughing
- Gastrointestinal: heartburn, nausea, constipation, diarrhea
- Urinary: urinary frequency, urgency, burning/pain with urination, incontinence
- Musculoskeletal: joint pain, swelling, stiffness, muscle pain
- Skin: skin changes, poor healing, rash, itching
- Neurological: numbness, tingling, unsteady gait, dizziness, tremors
- Hematological: easy bleeding, bruising

Are there any conditions or diseases not listed above that you have or have had?

_____

_____

_____

Do you smoke or use smokeless tobacco products? YES or NO If so, how often? _____

Do you consume alcohol? YES or NO If so, how often? _____

Do you use illicit drugs? YES or NO If so, what type and how often? _____

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Past Surgical History

Please list any surgeries you have had in the past 5 years or any major surgeries and year

_____
_____
_____
_____

Have you ever gotten an infection after surgery? YES or NO

Have you been hospitalized in the last 2 years? YES or NO If so, for what?

_____
_____

Have you had any major injuries in the last 5 years? YES or NO If so, what were they?

_____
_____
_____

Primary Care/Family Physician:

Name _____

Phone Number _____

To the best of my knowledge, the information above is accurate and inclusive.

Signature _____ Date _____

Printed Name _____

Simply Sculpt Employee Signature _____

Employee Printed Name _____ Date _____

(FOR STAFF USE ONLY)

Weight _____

Chest _____ Waist _____ Hips _____ Arms _____ Thighs _____ Other _____

30 S. Township Rd.
Suite E
Pataskala, OH 43062

740.407.6331
www.SimplySculptOhio.com

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Medication Alert

During the **TWO** weeks preceding your scheduled surgery, do **NOT** take any NSAID medications like aspirin, ibuprofen (Advil, motrin) or Naproxen (Aleeve). These medications affect your blood's ability to clot and could increase your tendency to bleed during surgery and during the recovery period.

- If you must take pain relievers, take Tylenol or acetaminophen. If you are allergic to acetaminophen or unable to take it for other reasons, please notify us so we can help find a suitable substitute for you.
- Please check the labels on all your medications, including any over the counter medication and supplements you take, to make certain you are not taking any that contain aspirin, ibuprofen or aspirin-like substances (Salicylic acid).
- If you are currently taking a medication and are unsure if it contains aspirin or a blood thinner, please contact us, your physician or your pharmacist.
- Before adding or starting a new medication before your procedure, be sure to consult us.

If you are taking any anti-rheumatoid, anti-arthritic, circulation or anti-coagulant medications such as Coumadin, Naprosyn or Persantine, etc. PLEASE inform us **immediately**. Some of these medications should not be taken for 14 days prior to the procedure. We will require you to get prior approval from your physician prior to the procedure as well as documentation that they are aware you will be off the medication.

Please complete the following about any medications or supplements you are currently taking and sign and date at the bottom. This information is important for your provider to be aware of prior to your procedure. If any of this information changes, please advise us immediately.

I currently take these **PRESCRIPTION** medications (include dose and how often):

_____

_____

_____

_____

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I currently take these **OVER-THE-COUNTER** medications (include dose and how often):

_____

_____

_____

_____

I currently take these **VITAMIN SUPPLEMENTS** (include dose and how often):

_____

_____

_____

_____

I currently take these **HERBAL SUPPLEMENTS** (include dose and how often):

_____

_____

_____

I HAVE REVIEWED THESE MEDICATION GUIDELINES AND PROVIDED MY MEDICATION HISTORY TO THE BEST OF MY KNOWLEDGE. I HAVE BEEN GIVEN A COPY TO REFER TO. FOR MY SAFETY, I WILL CALL MY PROVIDER IF ANY OF THE ABOVE MEDICATIONS CHANGE PRIOR TO MY PROCEDURE.

Patient signature: _____ Date: _____

Printed name of patient: _____

Simply Sculpt staff signature: _____ Date: _____

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