Amy T. Bandy, D.O., F.A.C.S.

Plastic and Reconstructive Surgery

Date: _____

PATIENT'S NAME:_____
Last name First name Middle initial

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME TELEPHONE#:_____ CELL PHONE#:_____

SEX: F M AGE:_____ DOB:_____ SSN:_____

DRIV. LIC.#:_____MARITAL STATUS:_____ SPOUSE'S NAME:_____

E-MAIL ADDRESS:_____

EMPLOYER:_____

OCCUPATION:_____WORK TEL#:_____EXT:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

EMERGENCY CONTACT:_____RELATIONSHIP:_____

HOME TEL#:_____ WORK TEL#:_____ CELL PHONE#:_____

DO YOU HAVE AN ADVANCE DIRECTIVE IN EFFECT? _____ YES _____ NO

May we contact you at work during business hours? ___Yes ___No
May we leave detailed messages at your home telephone number? ___Yes ___No

INSURANCE CO.:_____ TEL#:_____

ADDRESS:_____

NAME OF INSURED:_____RELATIONSHIP TO PATIENT_____

INSURED SS OR ID#: _____DOB _____GROUP#_____

INSURED'S EMPLOYER:_____ TEL#:_____

DO YOU HAVE SECONDARY INSURANCE? Yes___ No___

INSURANCE CO.:_____ TEL#:_____

I have had the opportunity to review Amy T. Bandy Medical Corp./Lido Surgical Institute's Notice of Privacy Practices and the Policy on Prohibition of Harassment as required by HIPPA regulation. A copy of this notice will be provided to me at my request.

Patient's Signature:_____ Date:_____

I authorize Dr. Bandy to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to Dr. Bandy. I understand that I am responsible for charges not covered by this assignment. I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original. I certify that the information I have reported with regard to my insurance coverage is correct.

Patient's Signature:_____ Date:_____

How did you hear about Dr. Bandy?

- ❑ ***Friend*** _____
- ❑ ***Patient*** _____
- ❑ ***Physician*** _____

Internet Search:

- ❑ ***RealSelf.com***
- ❑ ***Surgery.org (American Society of Aesthetic Plastic Surgery web site)***
- ❑ ***PlasticSurgery.org(American Society of Plastic Surgery web site***
- ❑ ***Yahoo.com***
- ❑ ***Other_____***
- ❑ ***Google.com***
- ❑ ***Loveyourlook.com***
- ❑ ***Bing.com***
- ❑ ***Yelp.com***
- ❑ ***CareCredit***
- ❑ ***Search term used_____***

Magazine/Newspaper:

- ❑ ***Coast Magazine***
- ❑ ***Orange Coast Magazine***
- ❑ ***Orange County Register (Best of OC)***
- ❑ ***Other_____***

What procedure(s) are you inquiring about today?

Have you met with other plastic surgeons for this type of consultation?

What type of plastic surgery have you had in the past, and are you happy with the results?

What are the most important factors to you when deciding where to have surgery?

Would you be interested in financing information?

What budget have you determined for your surgery? Estimate:

My time frame for surgery is:

- ❑ As soon as possible
- ❑ Soon
- ❑ 1-3 months from now
- ❑ 6-12 months from now
- ❑ Just need information

To better serve you, please let us know what other concerns you have that you would like more information about. Please check all that apply:

FACIAL:

- ❑ Facial aging/drooping
- ❑ Nose reshaping
- ❑ Frown lines/ wrinkles
- ❑ Lips shape/ thin lips
- ❑ Botox
- ❑ Skin care advice
- ❑ Facial Fillers (Juvederm,Restylane,Boletero)
- ❑ Length of Eyelashes- Latisse
- ❑ Chemical Peel or Laser resurfacing
- ❑ Brown/Age spots/ freckles/ Blotchy skin
- ❑ Sun damage
- ❑ Hollowness in face
- ❑ Torn or stretched earlobes
- ❑ Eyelid lift/ Drooping eyelids
- ❑ Mole removal
- ❑ Spider/Varicose Veins
- ❑ Scar revision
- ❑ Ear size/shape
- ❑ Neck wrinkles
- ❑ Neck looseness/ "turkey neck"
- ❑ Fatty neck
- ❑ Eyebrow/forehead lift
- ❑ Cheek/ chin augmentation

BODY:

- ❑ Breast size/ shape/ nipple or areola reduction
- ❑ Abdomen- excess skin or fat
- ❑ "Muffin top"
- ❑ Body Contouring- liposuction
- ❑ Thick thighs/ankles
- ❑ "Brazilian Buttlift"- buttock enhancement
- ❑ Mommy makeover
- ❑ Labiaplasty- rejuvenation of genitalia
- ❑ Gynecomastia- enlarged male breasts

SKIN CARE: (consult with an aesthetician)

- ☐ Waxing- bikini, face, legs, mustache, under arms
- ☐ Facials: acne, deep cleansing, anti-aging, moisturizing
- ☐ Micro-dermabrasion- exfoliating
- ☐ High frequency skin treatment to increase absorption of anti-aging products
- ☐ Ultrasound treatment for face-rebuilding collagen

Amy T. Bandy, D.O., F.A.C.S.

Health Screening Questionnaire

Name: Age: Date:

Occupation: All Previous Occupations:

Birth Place: Birthdate: List all states in which you have lived:

Education History: (Indicate Number of Years) High School: ☐ College: ☐ Post-Grad: ☐ Marital Status: Single ____Married ____ Divorced ____Widow(er) ____

Date of last physical examination: _____ List current medication, neutraceutical and herb dosages:_____

PERSONAL HISTORY: (please circle all answers)

Has ANY blood relative ever had

Bleeding disorder _____ No ☐ Yes ☐
Deep Vein Thrombosis_____ No ☐ Yes ☐
Pulmonary Embolism_____ No ☐ Yes ☐
Blood Clots_____ No ☐ Yes ☐
Anesthesia Complications__ No ☐ Yes ☐

Have YOU ever had

Bleeding disorder _____ No ☐ Yes ☐
Deep Vein Thrombosis_____ No ☐ Yes ☐
Pulmonary Embolism_____ No ☐ Yes ☐
Blood Clots_____ No ☐ Yes ☐
Anesthesia Complications__ No ☐ Yes ☐
Unexplained fainting spell __ No ☐ Yes ☐
Unexplained shortness of breath _____ No ☐ Yes ☐
Thrombophlebitis _____ No ☐ Yes ☐
Venous insufficiency _____ No ☐ Yes ☐
Cancer_____ No ☐ Yes ☐
Nephrotic Syndrome_____ No ☐ Yes ☐
Antiphospholipid Syndrome No ☐ Yes ☐
Lupus_____ No ☐ Yes ☐
Polycythemia_____ No ☐ Yes ☐
Homocystinemia_____ No ☐ Yes ☐
Radiation Therapy_____ No ☐ Yes ☐

ILLNESSES: Have you ever had

Measles_____ No ☐ Yes ☐
German Measles_____ No ☐ Yes ☐
Mumps _____ No ☐ Yes ☐
Chicken Pox _____ No ☐ Yes ☐
Whooping Cough _____ No ☐ Yes ☐
Scarlet Fever or Scarlentina_____ No ☐ Yes ☐
Diphtheria_____ No ☐ Yes ☐
Small Pox_____ No ☐ Yes ☐
Pneumonia_____ No ☐ Yes ☐
Influenza_____ No ☐ Yes ☐
Pleurisy_____ No ☐ Yes ☐
Rheumatic fever or Heart disease_____ No ☐ Yes ☐
Arthritis or Rheumatism_____ No ☐ Yes ☐
Any bone or joint disease_____ No ☐ Yes ☐
Neuritis or neuralgia_____ No ☐ Yes ☐
Bursitis, Sciatica or Lumbago_____ No ☐ Yes ☐
Polio or Meningitis _____ No ☐ Yes ☐
Nephritis _____ No ☐ Yes ☐

HPV, HSV I or II _____ No ☐ Yes ☐
Cold sores or Fever blisters__ No ☐ Yes ☐
Heart Murmur _____ No ☐ Yes ☐
Gonorrhea or Syphilis_____ No ☐ Yes ☐
Gallbladder disease_____ No ☐ Yes ☐
Jaundice _____ No ☐ Yes ☐
Bladder disease _____ No ☐ Yes ☐
Epilepsy _____ No ☐ Yes ☐
Migraine headaches_____ No ☐ Yes ☐
Tuberculosis_____ No ☐ Yes ☐
Diabetes _____ No ☐ Yes ☐
High or low blood pressure __ No ☐ Yes ☐
Colitis or other bowel disease _____ No ☐ Yes ☐
Hemorrhoids or any rectal disease _____ No ☐ Yes ☐
Anemia _____ No ☐ Yes ☐
Nervous Breakdown _____ No ☐ Yes ☐
Graves disease _____ No ☐ Yes ☐
Rosacea _____ No ☐ Yes ☐
Pemphigus _____ No ☐ Yes ☐
Thyroid disease _____ No ☐ Yes ☐
Eye disease _____ No ☐ Yes ☐
What type_____
Food, chemical or drug Poisoning _____ No ☐ Yes ☐
Hay fever or Asthma _____ No ☐ Yes ☐
Hives or Eczema _____ No ☐ Yes ☐
Frequent infections or boils __ No ☐ Yes ☐
Any other disease_____ No ☐ Yes ☐
If yes please list_____

Test positive for HIV_____ No ☐ Yes ☐
Hepatitis A, B or C _____ No ☐ Yes ☐

HAVE YOU EVER BEEN DIAGNOSED

Clinical depression _____ No ☐ Yes ☐
Obsessive-compulsive disorder _____ No ☐ Yes ☐
Schizophrenia _____ No ☐ Yes ☐
Personality disorder _____ No ☐ Yes ☐
Other psychiatric disorder ___ No ☐ Yes ☐

ALLERGIES: Are you allergic to

Penicillin or Sulfa _____ No ☐ Yes ☐
Aspirin, Codeine or Morphine_____ No ☐ Yes ☐
Mycins or other Antibiotics___ No ☐ Yes ☐
Merthiolate or Mercurochrome_____ No ☐ Yes ☐
Any other drug_____ No ☐ Yes ☐
Any foods_____ No ☐ Yes ☐
Adhesive Tape_____ No ☐ Yes ☐
Latex_____ No ☐ Yes ☐
Nail Polish or other Cosmetics _____ No ☐ Yes ☐
Tetanus Antoxin or Serums__ No ☐ Yes ☐

HEIGHT & WEIGHT:

Height _____ Weight _____
Weight one year ago_____
Maxiumun _____ When _____

TRANSFUSION: Have you ever had

Blood or Plasma Transfusion ☐ No Yes ☐

INJURIES: Have you had any

Broken or cracked bones ___ ☐ No Yes ☐
Sprains _____ ☐ No Yes ☐
Lacerations_____ ☐ No Yes ☐
Dislocations _____ ☐ No Yes ☐
Concussions or head injury___ ☐ No Yes ☐
Ever been knocked Unconscious _____ ☐ No Yes ☐

SMOKING:

Do you smoke now_____ ☐ No Yes ☐
If so, how much each day _____
How long have you smoked _____
If you don't smoke, have you ever in the past_____ ☐ No Yes ☐
For how many years _____
When did you quit? _____

SURGERY: Have you had

Tonsillectomy _____ ☐ No Yes ☐
Appendectomy_____ ☐ No Yes ☐
Any other operation_____ ☐ No Yes ☐
Type _____Year _____
Type _____Year _____
Have you ever been advised to have any surgical operation that has not been done _____ ☐ No Yes ☐
Have you ever been hospitalized?
For any illness? _____ ☐ No Yes ☐

DO YOU HAVE OR HAVE HAD WITHIN THE PAST YEAR

Frequent or severe headaches ☐ No ☐ Yes
Fainting spells ☐ No ☐ Yes
Dizziness on change of position ☐ No ☐ Yes
Unconscious spells ☐ No ☐ Yes
Blurred vision ☐ No ☐ Yes
Double vision ☐ No ☐ Yes
Infected eyes ☐ No ☐ Yes
Pain behind eyes ☐ No ☐ Yes
Any change in vision ☐ No ☐ Yes
Do you wear glasses? ☐ No ☐ Yes
When were they last checked?
Earaches ☐ No ☐ Yes
Recurrent nose bleeds ☐ No ☐ Yes
Recurrent head colds ☐ No ☐ Yes
Sinus trouble ☐ No ☐ Yes
Hay fever ☐ No ☐ Yes
Persistent hoarseness ☐ No ☐ Yes
Difficulty swallowing ☐ No ☐ Yes
Enlarged glands ☐ No ☐ Yes
Recurrent sore throats ☐ No ☐ Yes
Recurrent sores in mouth ☐ No ☐ Yes
Soreness or bleeding of gums on brushing ☐ No ☐ Yes
Chest pain ☐ No ☐ Yes
Angina pectoris ☐ No ☐ Yes
Coughed up blood ☐ No ☐ Yes
Pain in arm(s) ☐ No ☐ Yes
Night sweats ☐ No ☐ Yes
Chronic or frequent cough ☐ No ☐ Yes
Chronic or frequent cough on laying down ☐ No ☐ Yes
Wake up at night short of breath ☐ No ☐ Yes
How many bed pillows do you use? ☐
Do you have dry eyes? ☐ No ☐ Yes
Excessive tear production ☐ No ☐ Yes
Shortness of breath on:
Walking several blocks ☐ No ☐ Yes
One flight of stairs ☐ No ☐ Yes
On laying down ☐ No ☐ Yes
Purple lips or fingers ☐ No ☐ Yes
Palpitations or fluttering of heart ☐ No ☐ Yes
High blood pressure ☐ No ☐ Yes
Swelling of hands, feet or ankles ☐ No ☐ Yes
At what time of the day
Leg cramps on walking or at night ☐ No ☐ Yes
Enlarged veins in legs ☐ No ☐ Yes
Recurrent stomach pain ☐ No ☐ Yes
Belching or heartburn ☐ No ☐ Yes
Relieved by food or medication ☐ No ☐ Yes
Appetite – Good _____ Fair _____ Poor _____
Nausea or vomiting ☐ No ☐ Yes
Vomiting blood ☐ No ☐ Yes
Abdominal cramping ☐ No ☐ Yes
Color of bowel movement ☐
Any blood in BM ☐ No ☐ Yes
Rectal pain with bowel movement ☐ No ☐ Yes

MENSTRUAL HISTORY:

Age at onset _____ Regular? Yes _____ No _____ Varies _____
Date of last period _____ Date of last pelvic exam _____
Date of last Pap test _____ Results: Neg _____ Pos _____
Do you take birth control pills? ☐ No ☐ Yes
How long have you taken them _____
Pregnancies: How many children born alive ___ still ____ premature ____
How many Cesarean Sections _____
How many miscarriages _____

DO YOU HAVE OR HAVE HAD WITHIN THE PAST YEAR

Change in size, shape or texture of BM ☐ No ☐ Yes
Describe
Pain on urinating ☐ No ☐ Yes
Difficulty in starting urination ☐ No ☐ Yes
Do you get up at night to urinate? ☐ No ☐ Yes
How many times
Urinate more than before ☐ No ☐ Yes
Any blood in urine ☐ No ☐ Yes
Full feeling of bladder, but only small amounts of urination ☐ No ☐ Yes
Lose urine on coughing or sneezing ☐ No ☐ Yes
Discharge from penis/vagina ☐ No ☐ Yes
Recurrent back pains ☐ No ☐ Yes
Backaches ☐ No ☐ Yes
Joint pains ☐ No ☐ Yes
Swelling of any joints ☐ No ☐ Yes
Redness or heat of any joint ☐ No ☐ Yes
Tingling or weakness of hands or feet ☐ No ☐ Yes
Muscle spasm ☐ No ☐ Yes
Loss or change in sensation of hand or feet ☐ No ☐ Yes
Trembling of any extremity ☐ No ☐ Yes
Growth in neck or throat ☐ No ☐ Yes
Hot flashes ☐ No ☐ Yes
Tiredness without any apparent reason ☐ No ☐ Yes
Brittleness of nails ☐ No ☐ Yes
Dryness of skin ☐ No ☐ Yes
Easy bruising ☐ No ☐ Yes
Inability to stand heat ☐ No ☐ Yes
Inability to stand cold ☐ No ☐ Yes
Change in hair texture ☐ No ☐ Yes
Any skin rash ☐ No ☐ Yes

HAVE YOU EVER HAD X-RAYS OF:

Chest ☐ No ☐ Yes
Stomach or colon ☐ No ☐ Yes
Gall bladder ☐ No ☐ Yes
Extremities ☐ No ☐ Yes
Back ☐ No ☐ Yes
Teeth ☐ No ☐ Yes
Other ☐ No ☐ Yes

EKG: Ever had an electrocardiogram ☐ No ☐ Yes

IMMUNIZATION: Have you had?

Tetanus shots in last 5 years (not antitoxin that lasts only 2 weeks) ☐ No ☐ Yes
Polio shots within the last 2 years ☐ No ☐ Yes

MEDICATIONS:

Laxatives never ☐ occ ☐ freq ☐ daily ☐
Vitamins never ☐ occ ☐ freq ☐ daily ☐
Sedatives never ☐ occ ☐ freq ☐ daily ☐
Tranquilizers never ☐ occ ☐ freq ☐ daily ☐
Sleeping pills, etc. never ☐ occ ☐ freq ☐ daily ☐
Aspirin, etc. never ☐ occ ☐ freq ☐ daily ☐
Cortisone, Acet. never ☐ occ ☐ freq ☐ daily ☐
Thyroid never ☐ yes in the past, none now ☐
Daily appetite depressants daily ☐ now on ☐
Have you ever been treated for drug habits? ☐ No ☐ Yes
Have you ever been treated for alcohol related problems? ☐ No ☐ Yes
Have you ever taken insulin or tablets for diabetes? ☐ No ☐ Yes
Have you ever taken hormone tablets or injections? ☐ No ☐ Yes

Click Here to Submit

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Bandy will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.