



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:

- | | |
|---|---|
| <input type="checkbox"/> RealSelf.com | <input type="checkbox"/> Google.com |
| <input type="checkbox"/> Surgery.org (American Society of Aesthetic Plastic Surgery web site) | <input type="checkbox"/> Loveyourlook.com |
| <input type="checkbox"/> PlasticSurgery.org(American Society of Plastic Surgery web site) | <input type="checkbox"/> Bing.com |
| <input type="checkbox"/> Yahoo.com | <input type="checkbox"/> Yelp.com |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> CareCredit |
| | <input type="checkbox"/> Search term used _____ |

Magazine/Newspaper:

- | | |
|--|--|
| <input type="checkbox"/> Coast Magazine | <input type="checkbox"/> Orange County Register (Best of OC) |
| <input type="checkbox"/> Orange Coast Magazine | <input type="checkbox"/> 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:

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

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

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Health Screening Questionnaire

Name: _____ Age: _____ Date: _____

Occupation: _____ All Previous Occupations: _____

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

Education History: High School: College: Post-Grad: Marital Status: _____
 (Indicate Number of Years) Single ___ Married ___ Divorced ___ Widow(er) ___

Date of last physical examination: _____ List current medication, neurtaceutical 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
 Scarletina _____ 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 _____
 Maximum _____ 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

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.