



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?

Internet Search:

Drbandyblog.com
Perfectyourself.com
Breastaugmentation.com
Surgery.org
PlasticSurgery.org
Yahoo search
Google search
Ienhance.com
Loveyourlook.com
Thepatientsadvantage.com
Plasticsurgeon.com
Plasticsurgery.org
Surgery.org

Magazine/Newspaper:

Coast
Beach Reporter
Orange Coast
Dancers Magazine
Sign/Drive By
CareCredit
American Society of Plastic Surgeons
American Society of Aesthetic Plastic Surgeons

Yellow Pages:

Verizon
SBC

Patient: _____

Friend: _____

Doctor: _____

Other: _____

What procedure(s) are you inquiring about today? _____

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

Have you had ANY surgery in the past? _____ If yes, what type and when?

Are you pleased with your PLASTIC SURGERY results? _____

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

Would you be interested in financing information? _____

I have determined a budget for my procedure:

Yes _____

No _____

Estimate \$ _____ to _____

My time frame for surgery is:

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

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: 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 _____
 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