



grossman plastic surgery
 john a. grossman, m.d.
 philippe a. capraro, m.d.

4600 hale parkway suite 100
 denver, colorado 80220
 phone: 303-320-5566 or 800-394-0010
 fax: 303-320-1453

patient information

date: _____

john a. grossman, m.d. philippe a. capraro, m.d.

name: _____ social security #: _____

street address: _____ email: _____

city: _____ state: _____ zip: _____

home phone: _____ work phone: _____ cell phone: _____

may we contact you: at home? yes / no at work? yes / no on your cell? yes / no by email? yes / no

date of birth: _____ age: _____ gender: female male

marital status: married single divorced widowed

profession: _____ employer: _____

reason for consultation: _____

referred by: _____

responsible party

please provide the following information if someone other than the patient is responsible for payment

name: _____ social security #: _____

relationship to patient: spouse parent other _____

address: _____

city: _____ state: _____ zip: _____

home phone: _____ work phone: _____ cell phone: _____

do you intend to bill the medical services to your insurance? yes no

note: health insurance plans do not cover aesthetic surgery and procedures that are not considered medically necessary

emergency contact

name: _____ relationship: _____

address: _____

city: _____ state: _____ zip: _____

home phone: _____ work phone: _____ cell phone: _____

II. PAST MEDICAL HISTORY

a. What is your present: Height: _____ Weight: _____

b. Please indicate if you HAVE or have HAD any of the following medical problems:

	HAVE	HAD	COMMENTS/TREATMENT
High Blood Pressure			
Heart or Circulatory problems (eg. Chest pain/Heart Attack/ High cholesterol)			
Respiratory problems (eg. Asthma/Pneumonia/ Shortness of breath)			
Gastrointestinal Problems (eg. Ulcer/Hernia/Reflux)			
Genitounrinary Problems (eg. Voiding problems/ Menstrual problems/Impotence/Kidney stones)			
Endocrine/Immune Problems (eg. Thyroid problems/ Diabetes/HIV/AIDS/Lupus)			
Bleeding Problems (eg. Easy bruising/Clots/ Anemia)			
Musculoskeletal Problems (eg. Arthritis/Weakness/ Fibromyalgia/Limited mobility/ Numbness/Tingling)			
Cancer (please indicate type)			
Eye Problems (eg. Dry eyes/Glaucoma/Tearing)			
Nasal Problems (eg. Bleeding/Sinusitis/Difficulty breathing/Runny nose)			
Neurological/Emotional Problems (eg. Headaches/ Seizures/Depression)			

c. Please list any additional medical issues and any non-surgical hospitalizations or emergency room visits requiring treatment. (Please list additional problems on the last page.)

Year	Problem	Treating Physician

III. PAST SURGICAL HISTORY

a. Have you ever had surgery, including *Plastic Surgery*? **Yes** **No**

b. If you have had Plastic Surgery, please rate your results:

Excellent Good Fair Poor

c. If your results were fair or poor, please describe briefly.

d. Please list all prior surgical procedures. (This includes removal of tonsils/appendix/gallbladder, LASIK surgery, wisdom tooth extraction, etc.) List additional surgeries on the last page.

Year	Procedure	Surgeon	Complications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

e. If you have had surgery, check type(s) of anesthesia you received and circle any problem(s).

- General Anesthesia Nausea/Vomiting/Slow awakening/Difficult intubation/Other _____
- IV Sedation Nausea/Vomiting/Slow awakening/Other _____
- Epidural/Spinal Nausea/Vomiting/Insufficient/Bleeding/Headache/Other _____
- Block Insufficient /Prolonged/Systemic reaction Other _____
(eg. Axillary, regional, etc.)
- Local Insufficient block/Heart palpitations/Systemic reaction/Other _____

IV. MEDICATIONS

a. Do you require antibiotics prior to surgery? **Yes** **No**

If so, why? _____

b. Do you take any medications including vitamins? **Yes** **No**

c. If so, please indicate.

	Name	Dose
<input type="checkbox"/> Blood pressure pills	_____	_____
<input type="checkbox"/> Water pills	_____	_____
<input type="checkbox"/> Blood thinners	_____	_____
<input type="checkbox"/> Steroids	_____	_____
<input type="checkbox"/> Insulin	_____	_____
<input type="checkbox"/> Hormone replacement therapy	_____	_____
<input type="checkbox"/> Vitamins (eg. B, C, E, K, etc.)	_____	_____

- d. Please list ALL additional medications that you take. List additional medications on the last page.

Medication	Dose	Why?

- e. Do you take any herbs, dietary supplements, or weight reduction products? Yes No
If so, please circle.

Echinacea	Ephedra (<i>Ma Huang</i>)	Feverfew	Garlic	Gingko
Ginseng	Goldenseal	Kava-kava	Licorice	METABO-life
St. John's Wort	Saw palmetto	Valerian		

Others _____

- f. Do you take aspirin or ibuprofen products? Yes No
If so, please indicate.

- Aspirin (ASA/Bayer/Excedrin/Fiorinal/etc)
 Ibuprofen (eg. Advil/Motrin/etc)
 Non-steroidal anti-inflammatories (eg. Aleve/Anapro/Daypro/Toradol/etc)

Others _____

V. ALLERGIES & SENSITIVITIES

- a. Medication Allergies or Sensitivities? Yes No
If so, please indicate drug and circle reaction(s).

- Penicillin Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other _____
 Sulfa Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other _____
 Morphine Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other _____
 Codeine Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other _____

Other Medication(s)	Reaction
_____	Rash/Hives/Anaphylaxis/Swelling/Nausea/Vomiting/Other _____
_____	Rash/Hives/Anaphylaxis/Swelling/Nausea/Vomiting/Other _____

- b. Environmental or Food Allergies? Yes No

- c. Latex Allergies? Yes No

- d. Tape or Adhesive Sensitivities? Yes No

If so, please list type of tape or adhesive.

VI. SOCIAL HISTORY

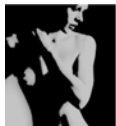
- a. Single Married Separated Divorced Widowed
- b. Children (birth years): _____
- c. Do you smoke?/Have you ever smoked? Yes No
If yes, please indicate and circle appropriate reply:
_____ Cig's or Packs/Day _____ x Years Quit _____ weeks/months/years ago
- d. Do you drink alcohol? ___ times/Day ___ times/Week ___ Rarely ___ Never
- f. Do you drink caffeinated beverages? Yes No If yes: _____/Day
- g. Do you use any recreational drugs? Yes No

VII. FAMILY HISTORY

Do you have a family history of:		Relationship	Problem
Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Breast cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Other cancers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Bleeding problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Anesthesia problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Other problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

VIII. ADDITIONAL INFORMATION

SIGNATURE: _____



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privacy practices acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how your Protected Health Information is disclosed for treatment, payment or health care operations. We are not required to agree to this restriction; but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Grossman Plastic Surgery provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient acknowledges that:

- Grossman Plastic Surgery has a Notice of Privacy Practices and that the patient received a copy of this notice and has the opportunity to review this notice.
- Protected Health Information may be disclosed for treatment, payment or health care operations.
- Grossman Plastic Surgery reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their protected health information, however, Grossman Plastic Surgery does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time, and all future disclosures will then cease.
- Grossman Plastic Surgery retains protected health information for **7 years** after the last date of treatment, or after the patient reaches the age of 18 (whichever occurs later), then destroyed according to our practice policy.

 Name of Patient or Patient Representative (Print or type)

 Signature of Patient or Patient Representative

 Date

 Relationship to Patient (if other than patient)

 Representative-Grossman Plastic Surgery



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photo consent

surgeon: john a. grossman, m.d. philippe a. capraro, m.d.

medical photo consent

I hereby give Grossman Plastic Surgery physicians and staff the absolute permission to photograph myself, for the medical reason (s) indicated at my consultation, and for pre and post operative care, only.

Name (please print) _____

Signature _____ Date _____

photo release

I hereby give Grossman Plastic Surgery physicians and staff the absolute right and permission to copyright and/or publish, or use photographic portraits of me, or in which I may be included in whole or in part, or reproductions thereof in color or otherwise, for presentations, photo albums, display on the company's web site, art trade, news or any other lawful purpose whatsoever. I hereby waive any right that I may have to inspect and/or approve the finished product or the advertising copy that may be used in connection therewith, or the use to which it may be applied.

Name (please print) _____

Signature _____ Date _____

Patient request re restricted use _____

Staff comments _____ *Date* _____

parent or guardian of a minor

I, the undersigned, being the parent or guardian of _____ do hereby consent and/or release of photos for the stated purpose above, and signature thereto.

Name (please print) _____

Signature _____ Date _____