Plastic Surgery New Patient Form

Name:_____Date:_____

Date of Your Last Physical Examination:_____

Name of Doctor:_____Height:_____Weight:_____

Address:_____

Birthday:_____Gender:_____

Phone Number:_____Email Address:_____

Part A. Surgery (Please list all operations including aesthetic surgery)

Type	Date	Complications or Difficulties

Part B. Medical Problems or Conditions Currently Under Treatment by a Physician

Please mention here if you have any stents in your heart or other blood vessels, or if you have ever had a stroke.

_____

_____

_____

Do you have any resolved medical issues (i.e. previous cancer, infectious disease, etc)? Please include here if you were infected with COVID 19 or had a known exposure to someone with it.

_____

_____

_____

Part C. Admissions to Hospital

Reason	Date	Complications or Difficulties

Part D. All Prescription and Over-the-Counter Medications, Vitamins, Herbal Supplements

Please make sure to include all weight control medications, the use of Accutane in the past year, antibiotics, aspirin, NSAIDs, steroids, chemotherapy, blood thinners, birth control, estrogen/hormones, and antidepressants.

Type	Dosage/Amount	Take How Often

Part E. Consumption of Certain Products

Type	Amount Daily	Amount Weekly
Aspirin		
Alcohol		
Tobacco		
Recreational Drugs		
Vaping Products		

Part F. Bleeding Tendencies

Do you bruise easily (yes or no):_____

With cuts/tooth extractions/pregnancy/surgery (circle)
Explain:_____

_____

Do you have a family history of bleeding problems:_____

_____

Part G. Blood Clotting

Do you have a history of blood clots, such as those in the leg, lungs, or brain?)_____

_____

Has anyone in you family ever had blood clot? Who and when?_____

_____

Do you have a history of 3 or more multiple miscarriages?_____

_____

Part H. Blood Transfusions

Have you ever had a blood transfusion?_____

Part I. Obstetrical History

Are you pregnant?_____

Last menstrual period:_____

Do you plan to become pregnant in the future?_____

Number of pregnancies you have had_____

Number of Live Births_____

Number of Miscarriages_____

Number of Stillborn Births_____

Number of Abortions_____

Part J. Other Medical History

Have you ever had or been exposed to any of the following (answer yes or no):

Intravenous Drugs_____

Infectious Diseases_____

TB_____

Hepatitis A_____

Hepatitis B_____

Hepatitis C_____

HIV/AIDS_____

Liver Disease_____

Liver Transplant_____

MRSA Infection_____

Implants of hardware anywhere in the body (head, spine, body, extremities)_____

Do you sunburn easily?_____

Do you have a history of keloid, hypertrophic, or poor scarring?_____

Do you have a sleeping disorder?_____

If so, do you use CPAP?_____

Part K. Neurological or Psychiatric Illness

Have you been diagnosed with a neurological or psychiatric illness?_____

Explain:_____

_____

Part L. Immunization History

Did you receive the following shots?

Type	Yes or No or Uncertain	Date if Known
Flu		
Tetanus		
Polio		
All childhood shots		

Part M. Screening Exams (answer for all those that are applicable):

Type	Date	Result
Mammogram		
Colonoscopy		
DEXA Scan		
Skin Exam		

PAP Smear/HPV _____ _____

Part N. Family History

Any family history of medical problems or illness in your father, mother, siblings, or other relatives (list condition and family relation):_____

_____

Has anyone in your family ever had issues or problems with any type of anesthesia?_____

_____

Part O. Allergies

Are you allergic to any medications, environmental substances, or foods?_____

_____

Part P. Anesthesia

Have you ever had any difficulties with local, regional, or general anesthesia? Please explain._____

_____

Part Q. Review of Systems

CHECK ANY PROBLEMS YOU HAVE HAD RECENTLY:

1. Constitutional (Over All): □ Fever □ Chills □ Fatigue □ Large Weight Gain □ Large Weight Loss

2. Integument (Skin): □ Acne □ Rash □Moles

3. Eyes: □ Vision Changes □Irritation

4. HENNT (Ears, Nose, Neck, Mouth & Throat): □ Hearing Loss □ Ear Pain □ Sore Throat □ Sinus Congestion

□ Sinus Pain □ Nasal Discharge □ Dental Problems □ Dry mouth □ Mouth Ulcers □ Neck pain

5. Respiratory (Lungs & Breathing): □ Cough □ Shortness of Breath □ Wheezing □Hemoptysis

6. Cardiovascular: □ Chest Pain □ Irregular Heart Beats □ Varicose Veins □ Rapid Heart Rate □Orthopnea

7. Gastrointestinal: □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Abdominal Pain □ Heartburn

□ Reflux □ Loss Of Appetite □ Hemorrhoids □ Blood In Stool □Dysphagia

8. Genitourinary (Genitals, Urinary Tract & Kidneys): □ Possible Pregnancy □ Irregular Menses

□ Missing Menses (Amenorrhea) □ Heavy Menses (Menorrhagia) □ Painful Menses (Dysmenorrhea) □ Blood Clots w/ Menses □ Pelvic Pain □ Vaginal Discharge □ Vaginal Itching □ Vaginal Odor

□ Vaginal Burning □ Vaginal Dryness □ Pain w/ Intercourse (Dyspareunia) □ Genital Swelling

□ Genital Sores □ PMS (Premenstrual Syndrome) □ Decreased Sex Drive (Libido) Pain w/ Urination (Dysuria)

□ Frequent Urination □ Urgency (Urgent Urination)

□ Incontinence (Not Able To Hold Urine) □ Pain From Bladder Around To The Back □ Blood In Urine □Hematuria

9. Endocrine (Hormones): □ Hot Flashes □ Night Sweats □ Increased Thirst (Polydipsia) □ Hair Loss □ Increased Urination (Polyuria) □ Cold Intolerance □ Heat Intolerance □ Excessive Body Hair (Hirsuitism)

□ PMS (Premenstrual Syndrome) □ Decreased Sex Drive (Libido) □ PMDD

10. Musculoskeletal (Muscles & Bones): □ Back Pain □ Muscle Pain □ Joint Pain □ Curvature of the Spine

11. Neurologic (Nerves): □Muscular Weakness □Tingling/Numbness □Difficulty concentrating □Memory Loss □ Headaches □ Dizziness □ LOC

12. Psychiatric: □ Difficulty Sleeping □ Depression □ Anxiety □ Suicidal Thoughts □ Anorexia □ Bulimia □ Alcoholism

13. Heme-Lymph: □ Easy Bruising □ Easy Bleeding □ Lymph Node Enlargement or Tenderness

14. Allergic-Immunologic (Protection Against Illness): □ Frequent Illnesses □ Allergy Symptoms

15. Breasts: □ Lumps □ Pain □ Swelling □ Redness □ Nipple Discharge □ Tenderness □ Implants □Breastfeeding

Part R. Signature

I certify that the information provided on this medical history is complete and correct. Further, I understand that providing incomplete and/or incorrect information may not only jeopardize my health, but also render ineffective or harmful, any treatment I receive from Dr. Ira Savetsky or McGuiness Dermatology.

Signature:_____

Date:_____

Aesthetic Patients

Consent for Irrevocable Non-Assignment

I understand that the procedure(s) I seek are cosmetic, not medically necessary and it would be fraudulent and unethical for Dr. Ira Savetsky and/or McGuiness Dermatology and Aesthetics to submit a charge to any insurance company for payment. Therefore, I understand that Dr. Ira Savetsky and/or McGuiness Dermatology will not accept insurance for my procedure(s). My consent to have Dr. Ira Savetsky and/or McGuiness Dermatology provide care and not accept assignment from any insurance company, managed care provider, or other coverage source is irrevocable and final. I understand that I will be fully responsible for the surgical fees for the procedure(s) I seek.

Signature of Patient or Parent/Guardian_____

Name of Patient or Parent/Guardian_____

Name of Patient if Under 18_____

Date_____

For All Patients

Pathology

I understand that all specimens removed in minor or major procedures are sent to pathology, and that I may be responsible for fees for the pathology service as determined by my insurance company.

Initial_____

Consent/Restriction of the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment, and any plans of future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the healthcare professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third party payer can verify that the services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. I wish to have the following restrictions to use of disclose my health information.

Circle One: None Other_____

Initial:_____

Consent to Photographs and Videos

I understand that as part of the appropriate process for keeping complete medical records, photographs and/or videos will be taken of me before, during, and after surgery or before, during, and after other procedures, or of any specimens that may be removed from me. I understand that, if appropriate, the photos may involve my face. A separate consent form for use of these images or footage for purposes outside of the medical record (or insurance as written below) has been provided on a separate page.

Initial_____

Release of Photographic Images for Insurance

I also understand that if I am pursuing care of any kind through a third party payor (i.e. my insurance company), my photographs be submitted as part of my medical record, in which case my name will be associated with the images.

Initial:_____

Signature:_____

Date:_____

AUTHORIZATION FOR RELEASE OF PATIENT PHOTOGRAPHS

Name:

I consent to the taking of photographs by Dr. Ira Savetsky, or his designee, of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Savetsky.

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

I certify that I have read the above Authorization and Release and fully understand its terms.

Patient:

(Print)_____ (Sign)_____ (Date)_____

Witness:

(Print)_____ (Sign)_____ (Date)_____

Parent / Guardian:

(Print)_____ (Sign)_____ (Date)_____

Photographic/Video Release and Social Media Consent

I hereby acknowledge that I have been advised that photographs and/or videos will be taken of me or parts of my body before, during, and after surgery or other procedure. The photographs may also be of specimens or implants removed from me. Some of these photographs may have been taken at visits prior to the date I have signed this form. The photographs and videos will be taken by medical personnel in the appropriate facility. I hereby give my consent to the use of photographs and videos under the following circumstances:

Photographs, electronic images, imaging records, illustrations, and video footage taken of me or parts of my body, implants or specimens removed from me, as well as details regarding medical service I have received at McGuiness Dermatology and Aesthetics may be used in any print, or broadcast or electronic media, including but not necessarily limited to newspapers, pamphlets, educational films, before and after books, scientific and professional journals, presentations at scientific or professional meetings, our internet site and television, and electronic media including, but not limited to Facebook, Instagram, RealSelf, YouTube, Twitter, Snapchat, TikTok, to inform the public about plastic surgery methods. Further, I release and discharge Dr. Ira Savetsky, Ira Savetsky, M.D., PLLC, and McGuiness Dermatology and Aesthetics, the facility in which the photographs or videos were taken, and the American Society of Plastic Surgeons/American Board of Plastic Surgery, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs, electronic images, illustrations, and video footage and details regarding medical services rendered me, including claim for payment in connection with any such user or publication. I give my consent as a voluntary contribution in the interest of public education.

I understand that once my images are published, I lose control over their use. I have no control over where they are published. I agree to give up certain rights to my image. I release any claim I may have to the publication of such images. This includes any payment for their distribution.

I understand that images posted online may be saved. They may be available forever. They may be found in online searches. I realize that people may repost my images without my surgeon's consent. This may be used in social media. Neither I nor my surgeon have any control over this. I agree that my surgeon is not responsible for third-party use. I release my surgeon from any claim that might arise from this use.

Initial_____

If undergoing a procedure of the face or head and neck, I understand that that photographs and videos of my face are a necessary and required part of complete documentation in my medical record. I do give permission for these facial photos and/or videos to be published in the media forms mentioned above without blocking any portion of the face, head, and neck. I understand that permitting use of these photos would render my face fully recognizable.

Initial_____

I understand that I shall not receive any financial compensation of any kind or at any time for the publication of images taken of me. I fully understand and consent to the images being the sole and exclusive property of Dr. Ira Savetsky, Ira Savetsky, M.D., PLLC, and McGuiness Dermatology and Aesthetics.

Initial_____

Signature of Patient or Parent/Guardian_____

Name of Patient or Parent/Guardian_____

Name of Patient if Patient is a Minor_____

Witness Signature _____

Date:_____

AMERICAN SOCIETY OF PLASTIC SURGEONS®

THROMBOSIS RISK FACTOR ASSESSMENT

VTE
ASPS CAMPAIGN FOR AWARENESS

CHOOSE ALL THAT APPLY

EACH RISK FACTOR REPRESENTS 1 POINT

- ❒ Age 41-60 years
- ❒ Minor surgery planned
- ❒ History of prior major surgery (< 1 month)
- ❒ Varicose veins
- ❒ History of inflammatory bowel disease
- ❒ Swollen legs (current)
- ❒ Obesity (BMI > 25)
- ❒ Acute myocardial infarction
- ❒ Congestive heart failure (<1 month)
- ❒ Sepsis (<1 month)
- ❒ Serious lung disease including pneumonia (<1 month)
- ❒ Abnormal pulmonary function (COPD)
- ❒ Medical patient currently at bed rest
- ❒ Other risk factors

_____

EACH RISK FACTOR REPRESENTS 2 POINTS

- ❒ Age 60-74 years
- ❒ Arthroscopic surgery
- ❒ Malignancy (present or previous)
- ❒ Major surgery (> 45 minutes)
- ❒ Laparoscopic surgery (> 45 minutes)
- ❒ Patient confined to bed (> 72 hours)
- ❒ Immobilizing plaster cast (< 1 month)
- ❒ Central venous access

EACH RISK FACTOR REPRESENTS 3 POINTS

- ❒ Age over 75 years
- ❒ History of DVT/PE
- ❒ Family history of thrombosis*
- ❒ Positive Factor V Leiden
- ❒ Positive Prothrombin 20210A
- ❒ Elevated serum homocysteine
- ❒ Positive lupus anticoagulant
- ❒ Elevated anticardiolipin antibodies
- ❒ Heparin-induced thrombocytopenia (HIT)
- ❒ Other congenital or acquired thrombophilia
  If yes:

Type:_____

** most frequently missed risk factor*

EACH RISK FACTOR REPRESENTS 5 POINTS

- ❒ Elective major lower extremity arthroplasty
- ❒ Hip, pelvis or leg fracture (< 1 month)
- ❒ Stroke (< 1 month)
- ❒ Multiple trauma (< 1 month)
- ❒ Acute spinal cord injury (paralysis) (< 1 month)

FOR WOMEN ONLY (EACH REPRESENTS 1 POINT)

- ❒ Oral contraceptives or hormone replacement therapy
- ❒ Pregnancy or postpartum (< 1 month)
- ❒ History of unexplained stillborn infant, recurrent spontaneous abortion ≥3), premature birth with toxemia or growth-restricted infant

TOTAL RISK FACTOR SCORE

2005 Caprini Risk Assessment Model
Reprinted with permission from
Joseph A. Caprini, MD

PATIENTS' NAME: _____

AGE: _____ SEX: _____

WEIGHT: _____

ASPS VTE TASK FORCE RISK ASSESSMENT AND PREVENTION

Approved by the ASPS Executive Committee in July 2011

Disclaimer: The recommendations were developed to provide strategies for patient management and to assist physicians in clinical decision making. The recommendations should not be construed as a rule, nor should it be deemed inclusive of all proper methods of care or exclusive of other methods of care reasonably directed at obtaining the appropriate results. The recommendations are not intended to define or serve as the standard of medical care. The ultimate judgment regarding the care of a particular patient must be made by the physician in light of all the circumstances presented by the patient, the diagnostic and treatment options available, and available resources.

STEP ONE: RISK STRATIFICATION

PATIENT POPULATION	RECOMMENDATION
In-patient adult aesthetic and reconstructive plastic surgery who undergo general anesthesia	**Should complete** a 2005 Caprini risk factor assessment tool in order to stratify patients into a VTE risk category based on their individual risk factors. **Grade B** **or** **Should complete** a VTE risk assessment tool comparable to the 2005 Caprini RAM in order to stratify patients into a VTE risk category based on their individual risk factors. **Grade D**
Out-patient adult aesthetic and reconstructive plastic surgery who undergo general anesthesia	**Should consider** completing a 2005 Caprini risk factor assessment tool in order to stratify patients into a VTE risk category based on their individual risk factors. **Grade B** **or** **Should consider** completing a VTE risk assessment tool comparable to the 2005 Caprini RAM in order to stratify patients into a VTE risk category based on their individual risk factors. Grade D

STEP TWO: PREVENTION

PATIENT POPULATION	2005 CAPRINI RAM SCORE*	RECOMMENDATION
Elective Surgery Patients adult aesthetic and reconstructive plastic surgery who undergo general anesthesia	**7 or more**	**Should consider** utilizing risk reduction strategies such as limiting OR times, weight reduction, discontinuing hormone replacement therapy and early postoperative mobilization. **Grade C**
Patients undergoing the following major procedures when the procedure is performed under general anesthesia lasting more than 60 minutes: ▶ Body contouring, ▶ Abdominoplasty, ▶ Breast reconstruction, ▶ Lower extremity procedures, ▶ Head/neck cancer procedures	**3 to 6**	**Should consider** the option to use postoperative LMWH or unfractionated heparin. **Grade B**
	3 or more	**Should consider** the option to utilize mechanical prophylaxis throughout the duration of chemical prophylaxis for non-ambulatory patients. **Grade D**
	7 or more	**Should strongly consider** the option to use extended LMWH postoperative prophylaxis. **Grade B**

The scores listed apply to the 2005 Caprini RAM and were not intended for use with alternative VTE risk assessment tools.

For the full task force report and prophylaxis medication, dosage, and timing protocol examples, visit plasticsurgery.org/vte

GRADE	QUALIFYING EVIDENCE	IMPLICATIONS FOR PRACTICE
A: Strong Recommendation	Level: I evidence or consistent findings from multiple studies of levels II, III, or IV	Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.
B: Recommendation	Levels: II, III, or IV evidence and findings are generally consistent	Clinicians should follow a recommendation but should remain alert to new information and sensitive to patient preferences.
C: Option	Levels: II, III, or IV evidence, but findings are inconsistent	Clinicians should be flexible in their decision-making regarding appropriate practice, although they may set bounds on alternatives; patient preference should have a substantial influencing role.
D: Option	Level: V little or no systematic empirical evidence	Clinicians should consider all options in their decision-making and be alert to new published evidence that clarifies the balance of benefit versus harm; patient preference should have a substantial influencing role.

**The 2005 Caprini VTE Risk Assessment Model has been validated in the plastic surgery population.*
Source: Pannucci CJ, Bailey SH, Dreszer G, et al. Validation of the Caprini risk assessment model in plastic and reconstructive surgery patients. J Am Coll Surg. 2011 Jan; 212(1):105-12.

COVID-19 RISK INFORMED CONSENT

I _____ (patient name) understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr. Ira Savetsky and all the staff at McGuiness Dermatology and Aesthetics are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr. Ira Savetsky and all the staff at McGuiness Dermatology and Aesthetics to proceed with the same.

I understand that, even if I have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, blood clots, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery.

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

_____

Patient or Person Authorized to Sign for Patient Date/Time

Witness_____Date/Time_____

I have been offered a copy of this consent form (patient's initials) _____

Aesthetic Patients

Consent for Irrevocable Non-Assignment

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Signature of Patient or Parent/Guardian_____

Name of Patient or Parent/Guardian_____

Name of Patient if Under 18_____

Date_____