Freeman
PLASTIC SURGERY
IDAHO FALLS & JACKSON HOLE

IDAHO FALLS
1855 MADISON AVE
IDAHO FALLS, ID 83404
(208) 881-5351

JACKSON HOLE
1921 MOOSE WILSON RD
WILSON, WY 83014
(307) 201-7121

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Contact Information

NAME

PHYSICAL STREET ADDRESS

CITY / STATE / ZIP

HOME PHONE | CELL PHONE

EMAIL ADDRESS | WANT MONTHLY SPECIALS? ☐ YES ☐ NO

DATE OF BIRTH | AGE | GENDER ☐ MALE ☐ FEMALE

HOW DID YOU HEAR ABOUT US?

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WHICH AREAS DO YOU WANT TO IMPROVE?

Face

- ❑ Wrinkles
- ❑ Age/brown spots
- ❑ Spider veins on nose and/or cheeks
- ❑ Rosacea
- ❑ Enlarged pores
- ❑ Raised moles or other lesions
- ❑ Aging skin
- ❑ Sagging skin
- ❑ Dull/grey pallor
- ❑ Aging area around eyes
- ❑ Aging area around mouth
- ❑ Scars

Body

- ❑ Sun damage on neck/decolletage
- ❑ Sun damage on backs of hands/arms/legs
- ❑ Localized fat deposits
- ❑ Scars
- ❑ Spider veins
- ❑ Breast issues

WHICH TREATMENTS ARE YOU INTERESTED IN?

Skin Quality

- ❑ Laser skin improvement - *best result with no downtime*
- ❑ Laser skin improvement - *best result with minimal downtime*
- ❑ Laser skin improvement - *best result possible*
- ❑ Acne / rosacea management
- ❑ Prescription skin care products

Facial Aesthetics

- ❑ Botox
- ❑ Dermal fillers
- ❑ Stem cell enriched fat as a facial filler

Body Aesthetics

- ❑ Liposculpture
- ❑ Spider vein treatments
- ❑ MiraDry to reduce sweating
- ❑ Laser skin improvement for body
- ❑ Freezing unwanted fat

We are also always researching, learning and considering new ideas. Please let us know if there are any other services you'd like us to add in the future:

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CURRENT MEDICATIONS

Aspirin	☐ YES	☐ NO
Anti-inflammatories *(Advil, Aleve, Celebrex, etc.)*	☐ YES	☐ NO
Anti-coagulants	☐ YES	☐ NO
Steroids	☐ YES	☐ NO

Please detail any of the above, or any other medications, either prescription or over-the-counter.

DIETARY SUPPLEMENTS

Please detail any dietary supplements that you take.

ALLERGIES

Do you have any allergies to food or medications?	☐ YES	☐ NO

Please detail any reactions or sensitivities to both food and medications.

PREGNANCY

Are you, or is it possible that you are pregnant or lactating	☐ YES	☐ NO

CIGARETTES / NICOTINE

How many packs of cigarettes do you use per week? *(Or if nicotine-containing products, how much?)*

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MEDICAL HISTORY

CONDITION	PATIENT	FAMILY
Healing or scarring problems, including keloids	☐ YES ☐ NO	☐ YES ☐ NO
Skin cancers	☐ YES ☐ NO	☐ YES ☐ NO
Severe allergies	☐ YES ☐ NO	☐ YES ☐ NO
Thrombophelbitis	☐ YES ☐ NO	☐ YES ☐ NO
Any bleeding problems	☐ YES ☐ NO	☐ YES ☐ NO
Herpes or cold sores	☐ YES ☐ NO	☐ YES ☐ NO
Eaton Lambert Disorder or Myashtenia Gravis	☐ YES ☐ NO	☐ YES ☐ NO
Diabetes or pre-diabetes	☐ YES ☐ NO	☐ YES ☐ NO
Numbness	☐ YES ☐ NO	☐ YES ☐ NO
Vision problems	☐ YES ☐ NO	☐ YES ☐ NO
Eye disease	☐ YES ☐ NO	☐ YES ☐ NO
Autoimmune or Immune Disease (including HIV/Aids)	☐ YES ☐ NO	☐ YES ☐ NO
Immunosuppresive therapy	☐ YES ☐ NO	☐ YES ☐ NO
Hepatitis	☐ YES ☐ NO	☐ YES ☐ NO
Tattoos or permanent makeup	☐ YES ☐ NO	☐ YES ☐ NO

Please fully describe any "yes" answers above, or any other medical problems

Have you had any previous surgeries? Please describe. Also describe any complications or problems

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CURRENT SKIN CARE ROUTINE (cleansers, moisurizers, sunscreen, etc.)

Please describe:

COSMETIC TREATMENT HISTORY

Have you ever used Accutane?	☐ YES ☐ NO	DATE
Complications, if any		

Previous Laser or IPL/BBL	☐ YES ☐ NO	DATE
Type of laser, if known		
Complications, if any		

Previous Dermal Fillers	☐ YES ☐ NO	DATE
Type of filler, if known		
Complications, if any		

Previous Botox (or other neuromodulator)	☐ YES ☐ NO	DATE
Type of neuromodulator, if known		
Complications, if any		

Other cosmetic treatments	☐ YES ☐ NO	DATE
Type (peel, microderm, surgery?) Provide detailed description		

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Please circle the number which best describes you. Please do your best - accurate answers are very important in ensuring that you receive a safe, effective treatment.

Ethnic origin is closest to:

- 1. Very fair skin (Celtic and Scandinavian)
- 2. Fair-skinned (Caucasian with light hair and light eyes)
- 3. Light-skinned (Caucasian with dark hair and dark eyes)
- 4. Olive-skinned (Mediterranean, some Asian, some Hispanic)
- 5. Dark-skinned (Middle Eastern, Hispanic, Asian, some Africans)
- 6. Very dark-skinned (African)

Natural hair color at age 18 was:

- 0. Red
- 1. Blonde
- 2. Light brown
- 3. Dark Brown
- 4. Black

Color of skin that is not normally exposed to sun:

- 0. Pink to reddish
- 1. Very pale
- 2. Pale with a beige tint
- 3. Light brown
- 4. Medium to dark brown
- 5. Dark brown to black

If I go out in the sun for an hour without sunscreen and haven't been in the sun in weeks, my skin will:

- 0. Burn, blister and peel
- 1. Burn, then when the burn resolves there is little or no color change
- 2. Burn, then turns tan quickly
- 3. Get pink, then turns to tan quickly
- 4. Just tan
- 5. My skin gets darker
- 6. My skin is so dark I can't tell

When was the last time the area to be treated was exposed to natural sunlight, tanning booths or artificial tanning cream?

- 0. Longer than one month ago
- 1. Within the past month
- 2. Within the past two weeks
- 3. Within the past week

Total Score:	Skin Type:
0-3 is Type I; 4-7 is Type II; 8-11 is type III; 12-15 is Type IV; 16-19 is Type V; 20-24 is Type VI	

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STATEMENT OF INFORMATION ACCURACY:

I understand that the information on these forms is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical questionaiire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors and omissions that I have made in the completion of this form. I understand that I am responsible for all charges associated with my treatment and that payment is due at the time of service.

PATIENT SIGNATURE	PRINTED NAME	DATE

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization creates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- *a basis for planning my care and treatment*
- *a means of communication among anyhealth professionals who contribute to my care*
- *a source of information for applying my diagnosis and medical information to my bill*
- *a means by which a third-party payer can verify that services billed were actually provided*
- *and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals*

I understand and have been offered a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

PATIENT SIGNATURE	PRINTED NAME	DATE

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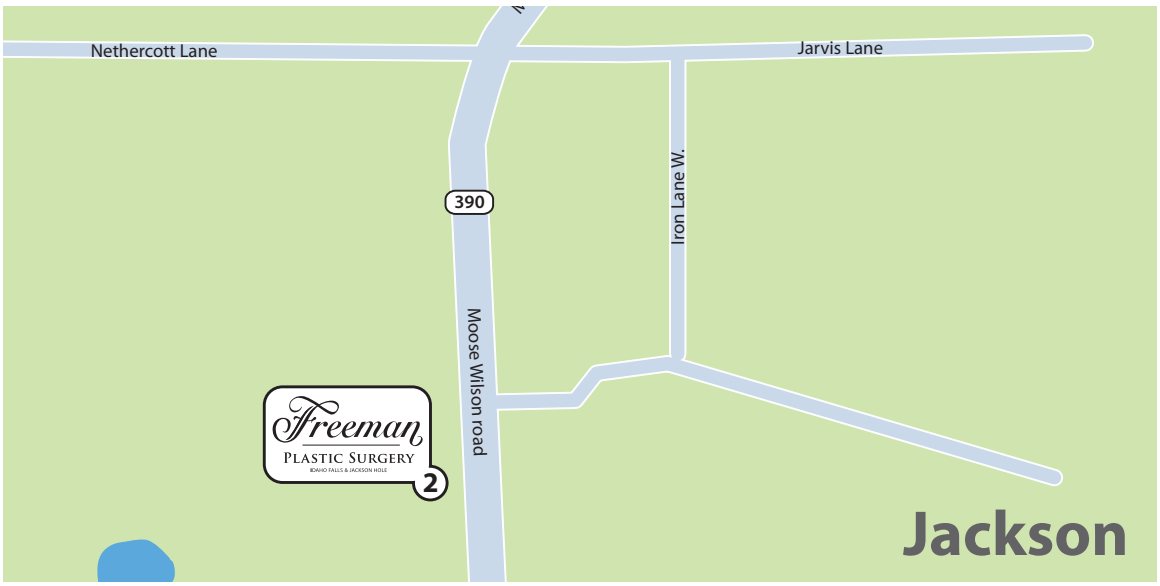
We can give you a much better assessment if we can see your natural skin in its natural condition. Please arrive WITHOUT makeup if at all possible, or at least be prepared to remove it. If possible, please also AVOID sun exposure and artificial tanners for a week before your appointment.



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