Aesthetic MEDICINE

4800 Meadows Rd Suite 100
Lake Oswego, Oregon 97035
P: 503-697-9777 F: 503-597-3708

Patient Application/ Medical Assessment

Date_____

Name_____ Date of Birth_____
Last **First** **Middle**

Person to notify in case of emergency:
Name: _____ Phone Number: _____

Relation: _____

Primary Care Physician
Name_____ Phone ( ) _____ Address _____

Date of last visit to this physician_____

Primary reason(s) for visit to any doctor(s) in the last two years (specify):

_____
_____
_____

Family History
Has anyone in your family had any of the following? : (If positive, indicate relation)
Obesity_____ Arthritis_____ Heart Disease_____
Stroke_____ Diabetes_____ Cancer_____

Patient-Medical (If you have had any of the following diseases, please indicate at what age).

Asthma:		**Cancer:**	
Gallstones:		**Kidney Stones:**	
Tuberculosis:		**Kidney Disease:**	
Rheumatic Fever:		**Ulcers:**	
Heart Disease:		**Bowel Disease:**	
High Cholesterol:		**Diabetes:**	
Gout:		**Arthritis:**	
High Blood Pressure:		**Sleep Apnea:**	
Thyroid Problem:		**Liver Disease:**	
Seizure/Convulsions:		**Pneumonia:**	
Psychiatric Disorder:		**History of Claustrophobia:**	
Other:			

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Have you ever had any issues with your heart, liver or kidneys? Y ☐ N ☐
Please explain:

Any issues with bleeding or history of blood clots? Y ☐ N ☐
(If yes please write when and what happened below)

_____

_____

Are you on any Blood thinners (Fish oil, Plavix, Warfarin, Aspirin, Ibuprofen, Aleve etc...) **?**
Y☐ N ☐ if yes please list

_____

_____

Do you have a pacemaker? Y☐ N ☐

Do you require antibiotics prior to dental procedures due to artificial joints or other reasons? Y ☐ N ☐ if yes please explain:

_____

_____

Could you be pregnant? Y ☐ N ☐

HOSPITALIZATION/SURGERIES (Diagnosis and Date):

_____

_____

_____

Have you ever had liposuction in the past? Y ☐ N ☐ Date:

_____

_____

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REVIEW OF SYSTEMS **Check yes or no**

HEENT	**YES**	**NO**
Frequent or constant headache		
Fainting spell, convulsions		
Dizziness		
Loss of vision/hearing		
Dental/Gum problems		
Lumps on neck		
Comments- Completed by physician		
CARDIO-RESPIRATORY		
Chest pain		
Shortness of Breath		
Chronic Cough/Sputum		
Leg cramps		
Varicose veins		
Pulmonary Embolism		
Phlebitis or inflamed leg veins		
Swelling of legs or ankles		
Rapid or irregular heart beat		
Comments – Completed by Physician		
URINARY		
Pain		
Blood		
Night-time frequency		
Comments – Completed by Physician		
GASTRO-INTESTIONAL		
Nausea or vomiting		
Constipation/ diarrhea		
Pain- Abdominal cramps		
Black stool/ blood in stool		
Comments- completed by Physician		

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REVIEW OF SYSTEMTS CONT.	YES	NO
REPRODUCTIVE (MALE)		
Impotence		
REPRODUCTIVE (FEMALE)		
Date of last menstrual period		
Comments- Completed by Physician		
SLEEP DISTURBANCES		
Daytime sleepiness		
Insomnia		
Sleep Apnea		
Comments- Completed by Physician		
ALLERGIES		
Do you have any medication allergies?		
If yes please list allergies	**Reaction**	
Current Medications:		
Drug	**Dose**	**Frequency/ Amount**

In the event that you receive a referral to another physician, do you give Aesthetic Medicine authorization to transfer your medical records to the referred physician?

Y ☐ N ☐ Initial: _____

The above information is true and correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Physician Review Signature: _____ Date: _____

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Photograph Consent Form

Patient's Name: _____

Date of Birth: ____/____/_____

I hereby authorize Aesthetic Medicine permission to photograph me for my before and after results.

I understand these photos will be used for medical purposes only and will not be released without my further consent.

_____ ____/____/____
Patient Signature Date

_____ ____/____/____
Aesthetic Medicine Representative Date

Aesthetic Medicine
4800 Meadows Road, Suite 100
Lake Oswego, OR 97035
www.drdarm.com
Phone: 503.697.9777
Fax: 503.597.3708

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Please review and initial after each of the following patient post procedure instructions:

_____ **Patient will arrange AND confirm a ride home prior to procedure date. This ride needs to arrive promptly after being notified the patient is ready post procedure.** (Please **do not** plan on driving yourself home as you will be medicated. Anyone caught driving themselves home will be "driving under the influence" and may be reported accordingly. There are no exceptions).

_____**Patient will have 24 hour care/ supervision from a responsible adult after the procedure.**

_____ **Patient will schedule and attend a follow up appointment 24-72 hours post procedure.**

By signing this form you acknowledge that you have received, acknowledge, and understand all of the following:

You agree to avoid Aspirin and Ibuprofen (10) days prior to surgery.
If you develop a rash, skin infection, an open wound, bladder infection, respiratory infection or any other illness of any kind prior to surgery, you will contact and inform our medical staff at that time at 503-697-9777.
I have read through all information given to me by Aesthetic Medicine regarding Laser Lipolysis procedure and agree to follow all instructions. Please initial that you have reviewed this information: **1. Questions and Answers _____ (included in patient education information)** **2. Instructions for care before the procedure_____** **3. Instructions for care after the procedure _____** **4. General surgical risks _____** **5. Information about prescriptions / medications _____** **6. Shopping list _____** **7. Photograph consent _____** **8. What you can expect the day of your procedure _____** ***These points are covered in the patient education packet. By initialing each one, you are stating that you have received and understand each page***

Patient Signature _____ Date _____

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IMPORTANT

WITHOUT A CAREGIVER AND DESIGNATED RIDE SURGERY WILL BE CANCELED EVEN ON THE DAY OF SURGERY.

I _____ understand that I will arrange for a caregiver. The caregiver will be responsible for my care on the day of my surgery to stay with me and monitor my recovery for 24 hours following the surgery.

I also understand that without a caregiver **and** a ride home that my surgery will be canceled even on the day of surgery.

_____ ____/____/____

Patient Printed Name Date of Birth

_____ ____/____/____

Patient Signature Date

_____ ____/____/____

Aesthetic Medicine Representative Date

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Preferred Pharmacy

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

Are there any medications that you are allergic or sensitive to? If so please list:

_____

_____

_____

_____

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Compression Garment Compliance Form

How Long Should a Compression Garment Be Worn?

Results are highly dependent on your compliance of following our instructions on wearing your compression garments.

Neck Garment: Wear 24 hours for 3 days, then wear 8-12 hours overnight for 30 days.
All other areas: After 24 hours post procedure, the garment can be taken off to be washed and you may shower using tepid water. Immediately put the compression garment back on for best results. Wear garment 24 hours a day for 3 weeks, only removing to shower. For best result we advise you to continue to wear the compression garment for an additional 6 weeks. You may purchase an additional compression garment (i.e.: Spanx) at your local department store.

The Benefits of a Compression Garment:

A compression garment has the potential to improve nearly every facet of your recovery. First, it ensures that incisions are kept clean in the early stages of healing, thereby reducing the risk of infection. Additionally, a compression garment aids in the following areas:

- Improved comfort: Compression of the surgical area minimizes the movement of damaged tissues, helping patients remain comfortable while relaxing or moving.
- Improved circulation: Compression has long been used to improve circulation, whether post-injury or during physical activity.
- Reduced bruising and swelling: With improved circulation, fluid retention is minimized; making bruising and swelling from surgery dissipate sooner.
- Reduced risk of complications: After body contouring, patients face a risk of fluid building up around the surgical site, resulting in a hematoma, seroma, or lymphedema. Compression garments promote fluid passage, thereby reducing the risk of blockage and complication.
- Reduced risk of skin irregularities: There is always a slight chance of skin healing irregularly over underlying tissues, or those tissues lumping together for an uneven appearance. A compression garment exerts even pressure over the area, improving skin adhesion and healing.

These benefits are even more noteworthy for patients with a history of irregular scarring, healing complications, or other risks that may threaten their final results. By wearing your compression garment as directed, along with the rest of your doctor's post-surgical instructions, you can enjoy a relatively easy and safe recovery.

What may happen if you do not wear your Compression Garment after your procedure?

For best possible surgical results, the garment is essential and the most important part of the recovery process. A compression garment will help prevent infection, help with fluid accumulation, and seromas. Failure to compress the treated areas can lead to inflammation; infection, and scar tissue. Your results may be less than satisfactory without following our compression guidelines. I have been informed and understand why the compression garment is the most important part of my surgical procedure and will comply with my physician's instructions.

Patient Name_____Signature _____Date_____

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Pre-Surgical Hibiclens Body Cleansing Instructions

You play an important role in your own health. Before your surgical procedure you must shower or bathe at home to clean your skin and reduce your chance of infection after your procedure.
Why is cleaning my skin before my surgical procedure important?
Your skin is not sterile so you will need to clean your skin before your surgical procedure. Your surgical team will make sure that your procedure area is done under sterile (germ-free) conditions. The antiseptic used to prepare your skin for the procedure will work better if your skin is clean.

Hibiclens is a skin cleaner and antiseptic. Hibiclens kills germs on contact and can continue to work up to 24 hours. It's gentle enough for even the most sensitive skin.

Steps for showering or bathing with Hibiclens: (If allergy reactions occur, stop using)

1. Shower/Bath night before and morning of your procedure.
2. Prep your shower/bath with clean washcloth, towel, and clothing.
3. Wash and rinse your hair, face, and body using your normal shampoo and soap.
4. Make sure you completely rinse off in a very thorough manner.
5. Turn off the shower, or step out of the bathwater.
6. Pour a quarter size amount of liquid Hibiclens soap onto a wet, clean washcloth, and apply to your entire body FROM THE NECK DOWN. Do NOT use on your face, hair, or genital areas.
7. Rub the soap filled washcloth over your entire body for 3 minutes; apply more soap as needed. Avoid scrubbing your skin too hard.
8. Turn on the shower/return to the bath, & rinse the soap off your body completely with warm water.
9. Do NOT use regular soap after washing with the Hibiclens.
10. Pat your skin dry with a freshly-laundered, clean towel after shower/bath cleanings.
11. Dress with freshly laundered clothes after shower/bath.
12. Do NOT apply any lotions, deodorants, powders, or perfumes to your body.
13. Wear clean and comfortable clothing upon arriving for your procedure.

Questions contact 503-697-9777 > Lipo Department

Signature that you received your sample of Hibiclens and shower/bathing instructions to help prevent any chance of an infection

Patient Name_____Signature_____Date_____

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Patient Rights and Responsibilities

Aesthetic Medicine provides you with the best in health care both in terms of treatment and patient experience. We respect your rights as a patient and want you to understand your responsibility as a partner in your care.

Patients' Rights

Aesthetic Medicine is committed to providing you with respectful care as we meet your health care needs. For this reason, we provide the following summary of your rights as a patient:

- You have a right to considerate and respectful care.
- You have the right to participate in the development and implementation of your plan of care.
- You will not be denied access to care due to race, creed, color, national origin, sex, age, sexual orientation, religion, disability or source of payment.
- You have the right to information about your treatment in terms that you can understand.
- You are entitled to be free from all forms of abuse or harassment.
- You have the right to make or have a representative of your choice make informed decisions about your care and have family input in care decisions.
- You have the right to appropriate assessment and management of pain.
- You are entitled to be free from any forms of restraint or seclusion as a means of convenience, discipline, coercion or retaliation.
- You are entitled to information about rules and regulations affecting your care or conduct.
- You have the right to know the names and professional titles of your physicians and caregivers.
- You have the right to personal privacy and to receive care in a safe and clean environment.
- You have the right to a prompt and reasonable response to any request for services within the capacity of the medical facility.
- You have the right to express concerns or grievances regarding your care to the staff.
- The confidentiality of your private health information will be maintained.
- You have the right to request to see your health record within the limits of the law.
- You have the right to an explanation of all items on your bill. You have the right to be provided with information about your treatment needs and follow up care.
- You have the right to be informed of unanticipated outcomes.

Patients' Responsibilities

This is a summary of your responsibilities as a patient of ***Aesthetic Medicine***

- It is your responsibility to provide accurate and complete information about all matters pertaining to your health, including medications and past or present medical problems.
- You are responsible for following the instructions and advice of your care team. If you do not follow the instructions or advice, you must accept the consequences of your actions.
- It is your responsibility to notify a member of the care team if you do not understand information about your care and treatment.
- You are responsible for reporting changes in your condition or symptoms, including pain, to a member of the care team.

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- It is your responsibility to act in a considerate and cooperative manner and to respect the rights and property of others.
- You are responsible for following the rules and regulations of ***Aesthetic Medicine.***
- You are expected to keep your scheduled appointments or to cancel them in advance if possible.
- It is your responsibility to pay your bills or make some arrangement with the facility to meet your financial obligations.
- You have the right to provide a copy of an Advanced Directive to the front desk personnel to be placed in your medical record. If you would like information about Advanced Directive, please ask the front desk personnel. **Your Advanced Directive will be suspended for the duration of your visit to our office-based surgery center.**

Patient Privacy Policies

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION:

WHO WILL FOLLOW THIS NOTICE:

- This notice describes the information privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION:

- This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.
- We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.
- For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.
- Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at the office.
- Treatment Alternatives, Health-Related Products and Services: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

SPECIAL SITUATIONS

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- To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- Required By Law: We will disclose health information about you when required to do so by federal, state or local law.
- Law Enforcement, Lawsuits and Disputes: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Questions or Concerns? You and your family should feel you can always voice your concerns. If you share a concern or complaint, your care will not be affected in any way. The first step is to discuss your concerns with your doctor, nurse, or other caregiver. If you have concerns that are not resolved, please contact ***Aesthetic Medicine Practice Administrator at (503) 697-9777.*** Should you continue to remain concerned after contacting the ***Practice Administrator*** you may contact the ***Institute of Medical Quality (IMQ) at (415)882-5151***

_____ _____/_____/_____

Patient Printed Name **Date**

_____

Patient Signature

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Smoking Informed Waiver and Consent for Elective Surgery

Smoking, Second-Hand Smoke Exposure, Nicotine Products (Patch, Gum, Nasal Spray):

Patients who are currently smoking or use tobacco or nicotine products excessively (patch, gum, or nasal spray) are at a greater risk for significant surgical complications of surgical infections, delayed healing and additional scarring. Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to nicotine exposure. Additionally, smoking may have a significant negative effect on anesthesia and cause complications from anesthesia recovery, such as pneumonia, excessive coughing and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine-containing products have a significantly lower risk of these types of complications. Please indicate your current status regarding these items below:

_____I am a non-smoker and do not use nicotine products. I understand the potential risk of second-hand smoke exposure causing surgical complications.

_____I am a smoker or use tobacco/nicotine products. I understand the risk of surgical complications due to smoking or use of excessive nicotine products.

_____I have smoked and stopped approximately _____ ago. I understand I may still have the effects and therefore risks from smoking in my system, if not enough time has lapsed.

It is important to refrain from smoking at least 10 days before surgery and until your physician states it is safe to return, usually 10 additional days. I acknowledge that I will inform my physician if I continue to smoke within this time frame, and understand that for my safety, the surgery may be delayed if your surgeon feels your smoking represents an unacceptable risk.

Patient Name_____ Signature _____ Date_____

Aesthetic Medicine Representative _____

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PREGNANCY TEST CONSENT & RELEASE FORM

TEST INFORMATION

Our pregnancy test is 97- 99% accurate, however there are many factors that can affect the accuracy of the results of the test such as the presence of drugs in the system. A physician through a blood test can provide a 100% confirmation of pregnancy. If your test is negative, you may return in 1 week for a retest.

Be aware that if your test is positive today, and you have a history of medical problems and/or are on any medication, you should consult your primary care physician for follow-up care.

Aesthetic Medicine's pregnancy tests are medical grade tests designed to detect the hormone "human chorionic gonadotropin", commonly abbreviated as hCG, which is produced by the placenta in the very early stages of pregnancy. hCG is first produced when the fertilized egg (or embryo) "implants" in the uterus. This takes place about six days or so after conception, or the union of sperm and egg. Fertilization takes place in the fallopian tube. Once the egg is fertilized, the embryo travels down the fallopian tube to the uterus. Once in the uterus, the embryo will implant in the lining of the uterine wall. At this point, the placenta develops and hCG is rapidly produced. This whole process between ovulation and implantation may take five to seven days or so.

Following implantation of the embryo, the amount of hCG increases rapidly - on a daily basis, nearly exponentially. The hCG hormone does travel through the woman's system and ultimately appears in urine samples. Urine pregnancy tests function by detecting the amount of the hCG hormone in the urine. You can also go to your doctor to have blood drawn - another way of determining if you are pregnant.

PROCEDURE

For best results on your pregnancy test:

- Place 4 drops of urine to the sample well, urine will then move across the surface of the test device
- Wait for 5 minutes
- A pink colored band that lines up with the C (Control Band) indicating the test is working
- A second pink colored band that lines up with the T (Test Band) indicating a positive test

CONFIDENTIALITY

Results are kept confidential and pregnancy verification will only be made available to you upon request with a signed medical release form and proper identification.

CONSENT

I have read and understand the above and consent that Aesthetic Medicine may perform a urine pregnancy test.

_____ ____/____/____

Patient Signature or Legal Representative — Date

_____ ____/____/____

Aesthetic Medicine Representative — Date

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Medication Use Agreement

Patient Name: _____ Date of Birth: ____/____/____

Surgery Date Scheduled: _____/_____/_____

Pharmacy Name: _____ Pharmacy Phone: _____

In preparation for your upcoming surgery, your surgeon has prescribed medications as a precautionary measure to prevent infection and promote postoperative healing. It is very important that you follow the medication dosing instructions exactly as prescribed. Failure to do so puts your health at risk and may interfere with the desired outcome of your procedure.

The following medications have been prescribed to you by your surgeon and must be taken as instructed:

□ Keflex® 500mg :Instructions: Take one dose 4 times per day, starting one day prior to surgery. Continue until gone.

OR

□ Antibiotic alternate:

_____

_____

□ Xanax® 1mg Instructions: Bring with you on the day of surgery. Wait to take until medical staff advise prior to procedure.

□ Zofran® 4mg Instructions: Take one dose every 6-8 hours as needed for nausea. Bring with you on the day of surgery.

Acknowledgment

I have received my prescription(s) as described above and the instructions for their use. I understand that failure to comply with these instructions puts my health at risk and may jeopardize the desired outcome of my procedure.

I also understand that my surgery may be postponed at the discretion of Aesthetic Medicine. If I do not comply with the instructions for medications that must be taken prior to surgery and that if my surgery is postponed as a result of my failure to comply, a cancellation/rescheduling fee will be assessed.

_____ _____/_____/_____

Patient Signature Date

_____ _____/_____/_____

Aesthetic Medicine Medical Representative Date

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PRO-NOX Analgesia Consent Form for Administration of Nitrous Oxide for Pain & Anxiety

Under the discretion of the clinician a 50% Nitrous 50% Oxygen ProNox may be self-administered during lipolysis procedure for analgesia or anxiety. I understand from Aesthetic Medicine and staff that there are several contraindications for use of Nitrous Oxide through the PRO-NOX system. They are listed below.

SPO2 Must be 95% on room air or higher to use PRO-NOX

CONTRAINDICATIONS

- Hypersensitivity to nitrous oxide mixtures
- Head injuries with impaired consciousness
- Maxillofacial injuries
- Artificial, traumatic or spontaneous pneumothorax or pulmonary hypertension
- Air embolism
- Middle ear occlusion, ear infection
  - Eye Surgery with intra-ocular gas injection within the last 6 weeks
- Decompression sickness
- Severe abdominal distension secondary to intra-abdominal air / intestinal obstruction
- Inability of patient to follow directions
- Inability of patient to hold own delivery device (mouthpiece or mask)
- Patients with systolic blood pressure consistently less than 85.
- B12 deficiency

Medications contraindicated:

- Isocarboxazid
- Methotrexate
- Phenelzine
- Selegiline
- Tranylcypromine

I acknowledge that I do not have any of these conditions and consent to the use of Pro-Nox for my procedure today and in the future.

_____ _____

Signature of Patient or Legal Agent/Guardian Date

_____ _____

Aesthetic Medicine Employee Witness Date

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Thrombosis Risk Assessment

Patient's Name: _____ Date of Birth: _____/_____/_____ Sex: M/F

Date: _____/_____/_____

CHOOSE ALL THAT APPLY:

RISK – One Point Each	YES	NO
Age 41-60 years of age		
Minor surgery planned		
History of prior surgery (<1month)		
Varicose Veins		
History of Inflammatory Bowel Disease		
Swollen Legs (current)		
Obesity (BMI >30)		
Acute Myocardial Infarction		
Congestive Heart Failure		
Sepsis		
Serious lung disease including pneumonia		
Abnormal pulmonary function (COPD)		
Medical patient currently on bed rest		
Total Number of each Column		
RISK – Two Point Each	**YES**	**NO**
Age 60-74 years of age		
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)		
Total Number of each Column		
RISK – Three Point Each	**YES**	**NO**
Age 75 years		
Family history of thrombosis		
Positive factor V Leiden		
Major surgery (>45 minutes)		
Positive prothrombin 20210A		
Elevated serum homocysteine		

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Positive lupus anticoagulant		
Elevated anticardiolipin antibodies		
Heparin-induced thrombocytopenia (HIT)		
Other congenital or acquired thrombophilia		
Total Number of each Column		
RISK – Five Point Each	**YES**	**NO**
Elective major lower extremity arthoplasty		
Hip, pelvis, or leg fracture (<1 month)		
Stroke (<1 month)		
Multiple trauma (<1 month)		
Acute spinal cord injury (paralysis) (< 1 month)		
Total Number of each Column		
RISK – WOMEN ONLY – 1 Point Each	**YES**	**NO**
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 Number of each Column		

Total Risk Score: _____ _____

Physician Signature: _____ **Date:** _____/_____/_____