Perfection
Plastic Surgery | Skin Care
Peter P. Kay, M.D., F.A.C.S., F.R.C.S. (C), F.R.C.S. (Ed)
2355 North Wyatt Drive, Suite 111 | Tucson, Arizona 85712
T: 520-323-7100 | F: 520-323-2228

We, at *Perfection Plastic Surgery & Skin Care*, have made a philosophical commitment to set as our goal: "Perfection" in everything we do—whether it is correcting prominent ears on a child, lifting a face, or sculpting a body. Only "God" is in all things perfect, but by striving for perfection, we feel we will constantly be challenged to improve in our pursuit of excellence.

We feel strongly about providing confidential and personal care to our patients. We believe this is essential for you to heal and fully recover, to enjoy the rejuvenating results of your skin care and your cosmetic surgery.

We have worked extensively and deliberately to create a form that will provide us with a comprehensive health history to last the longevity of your time on our practice. We appreciate the time and thought you contribute in filling out the attached forms. This information will allow us to care for you in an informed, thorough, and safe manner. Lastly, but no less important, it will help us learn something about you, your concerns, and your interests, so that we may treat you in a caring, personal way, taking all this information into consideration as we make recommendations and prepare an individualized treatment plan.

Thank you for entrusting your care to us.

Peter Kay, M.D., F.A.C.S., F.R.C.S. (C), F.R.C.S. (Ed)
Denise Lopez, Lisa Bielat, Edlin Coronado, Eberi Virgen, Carolina Medina—Front Office Staff
Kathy Wilson, R.N., B.S.N.—Patient Care Coordinator, Nurse Injector
Karen Martin, C.S.A.—Certified Surgical Assistant
Regina Todd, C.S.A., P.C.C.—Compliance Coordinator
Cheryl Hoge, R.N., B.S.N.— Laser Certified Skin Care Specialist
RoseMarie Foote, R.N.—Laser Certified Skin Care Specialist, Nurse Injector
Michelle Jawors—Laser Certified Skin Care Specialist
Angela Sollenbarger, R.N., B.S.N. — Nurse Injector, Skin Care Specialist
Vanessa Estes, R.N. — Nurse Injector, Laser Certified Skin Care Specialist
Casey Kay—Practice Manager

Please complete this health history form at your convenience and bring it to your appointment at *Perfection Plastic Surgery & Skin Care*.

Thank you!

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Date: _____/_____/_____

COMPREHENSIVE SURGICAL HEALTH HISTORY

Name: _____
First Middle Last

Date of Birth: _____/_____/_____ Age: _____

☐ Ms. ☐ Mrs. ☐ Mr. ☐ Dr. ☐ Single ☐ Married ☐ Divorced ☐ Life Partner ☐ Widowed ☐ Separated

Reason for consultation/Areas of concern: _____

_____

Local Address: _____
Street City State Zip Code

Alternate Address (If Applicable) ☐ Same as above _____
Street City State Zip Code

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

E-mail*: _____

☐ *YES! Sign me up for periodic emails with information on new technology, in office events, and specials.*
**The email address you provide will NOT be shared with outside parties.*

Preferred method of contact: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-mail ☐ Text

Employer: _____ Occupation: _____

☐ Husband ☐ Wife ☐ Partner Name: _____
First Last

Employer: _____ Occupation: _____

Work Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Parent (If Patient is a Minor): _____
First Last

Person to Contact in Case of an Emergency: _____
First Last

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Your referral source: _____

Revised February 2017

PERSONAL MEDICAL HISTORY

Height: _____ Weight: _____ BMI: _____ Recent Weight Change: ☐ Gained _____lbs ☐ Lost _____lbs

Do you have allergic reactions to any medications, ointments, environmental allergens, etc.?

Allergies:	Reactions:
_____	_____
_____	_____
_____	_____

Please list medications, diet aides, weight loss or appetite suppressants/supplements you are currently taking.

Medications/Supplements	Dosage	How Often Taken	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any previous surgeries, including cosmetic procedures and skin treatments.

Surgeries	Year	Surgeon & Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Care Physician: _____ Telephone #:_____

Date of Last Physical Exam: _____/_____/_____

Any Other Specialists Who Take Care of You:

Name	Specialty
_____	_____
_____	_____

HABITS

Alcohol Intake: ☐ Yes ☐ No
☐ Wine: How much? _____ How often? _____
☐ Beer: How much? _____ How often? _____
☐ Spirits: How much? _____ How often? _____

Recreational Drugs:
- Do you use recreational drugs? ☐ Yes ☐ No

Marijuana ☐ Cocaine ☐ Other ☐ _____
How much? _____
How often? _____

Tobacco Use:
- Current Smoker: ☐ Yes ☐ No
  How much? _____
  How long? _____
- Previous Smoker: ☐ Yes ☐ No
  How much? _____
  When stopped? _____
- Do you use Nicotine Patches/Nicorette Gum? ☐ Yes ☐ No
- Do you use E-cigarettes? ☐ Yes ☐ No
- Do you use chewing tobacco? ☐ Yes ☐ No

List your exercise habits: _____

Revised February 2017

Do you have OR have you had any of the following:

If you check yes for a category, please mark the applicable symptoms and explain.

HEART and BLOOD VESSEL problems? ☐ **Yes** ***(Specify Below)*** ☐ **No**

- ☐ Heart Murmur: _____
- ☐ High / Low Blood Pressure: _____
- ☐ High/Low Cholesterol: _____
- ☐ Heart Attack: _____
- ☐ Heart Stents / Pacemaker / Heart Valve: _____
- ☐ Heart Surgery: _____
- ☐ Angina or Chest Pain: _____
- ☐ Heart Failure: _____
- ☐ Irregular Heart Beat: _____
- ☐ Shortness of Breath: _____
- ☐ History of Stroke: _____
- ☐ Leg or Buttock Cramps when Walking: _____
- ☐ Varicose Veins: _____
- ☐ Swollen Legs/Ankles: _____
- ☐ Abnormal Cardiac Tests (i.e., EKG, Stress Test, etc.): _____
- ☐ Other: _____

LUNG problems? ☐ **Yes** ***(Specify Below)*** ☐ **No**

- ☐ Asthma: _____
- ☐ Chronic Cough: _____
- ☐ Wheezing: _____
- ☐ Lung Surgery: _____
- ☐ Emphysema: _____
- ☐ Abnormal Chest X-Ray: _____
- ☐ Lung Infections (i.e., Bronchitis, TB, etc.): _____
- ☐ Other: _____

CIRCULATORY (blood) problems? ☐ **Yes** ***(Specify Below)*** ☐ **No**

- ☐ Bleed Easily: _____
- ☐ Bruise Easily: _____
- ☐ Anemia: _____
- ☐ Blood Clots in Legs / Lungs (Pulmonary Embolus): _____
- ☐ Low Platelet Levels / Low Potassium: _____
- ☐ Enlarged Spleen: _____
- ☐ Abnormal Blood Tests: _____
- ☐ Enlarged Lymph Nodes: _____
- ☐ Hemophilia: _____
- ☐ Blood/ Plasma Transfusions: _____
- ☐ Phlebitis: _____
- ☐ Spider Veins: _____
- ☐ Take Blood Thinners: _____
- ☐ Carotid Artery Narrowing: _____
- ☐ Reynaud's _____
- ☐ Other: _____

KIDNEY DISEASE? ☐ **Yes** ***(Specify Below)*** ☐ **No**

- ☐ Kidney Failure: _____
- ☐ Kidney Infection: _____
- ☐ Kidney Stones: _____
- ☐ Frequency of Urination: _____

GASTROINTESTINAL problems? ☐ **Yes** ***(Specify Below)*** ☐ **No**

- ☐ History of Gastric Reflux/Heartburn: _____
- ☐ Hiatal Hernia / Other Hernias: _____
- ☐ Stomach Ulcers: _____
- ☐ Nausea and Vomiting: _____
- ☐ Constipation: _____
- ☐ Irritable Bowel: _____
- ☐ Gas Bloating: _____
- ☐ Gallbladder Related Issues: _____
- ☐ Small Bowel Disease: _____
- ☐ Diverticulitis: _____
- ☐ Bowel Inflammation (Colitis): _____
- ☐ Liver Disease / Jaundice: _____
- ☐ Other: _____
- ☐ Urgency of Urination: _____
- ☐ Prolapsed Bladder: _____
- ☐ Blood in Urine: _____
- ☐ Other: _____

ENDOCRINE SYSTEM problems? ☐ **Yes** ***(Specify Below)*** ☐ **No**

- ☐ Diabetes: _____
- ☐ Thyroid High: _____
- ☐ Thyroid Low: _____
- ☐ Thyroid Surgery: _____
- ☐ Adrenal Gland Problems (Cushing's Syndrome): _____
- ☐ Pituitary Gland Problems: _____
- ☐ AIDS (Exposure Of / Tested For): _____
- ☐ Other: _____

SKIN problems? ☐ **Yes *(Specify Below)*** ☐ **No**

- ☐ Excessive Sun Exposure: _____
- ☐ Skin Cancers: _____
- ☐ Skin Allergies/Sensitivities: _____
- ☐ Thick Scar Formation: _____
- ☐ Shingles: _____
- ☐ Cold Sores: _____
- ☐ Non-Healing Sores/Boils: _____
- ☐ Rashes: _____
- ☐ Autoimmune Diseases (i.e., Lupus, Scleroderma, Raynaud's Disease, etc.): _____
- ☐ Difficulty Healing: _____
- ☐ Sensitivity to Suture Material: _____
- ☐ History of Steroid Injections: _____
- ☐ Other: _____

INFECTIONS? ☐ **Yes *(Specify Below)*** ☐ **No**

- ☐ Chicken Pox: _____
- ☐ Mononucleosis: _____
- ☐ Herpes: _____
- ☐ Hepatitis: _____
- ☐ MRSA: _____
- ☐ Other: _____

EARS? ☐ **Yes *(Specify Below)*** ☐ **No**

- ☐ Hearing Loss: _____
- ☐ Hearing Aids: ☐ Right ☐ Left
- ☐ Ear Infections as a Child / Tubes: _____
- ☐ Inner Ear Dizziness: _____
- ☐ Other: _____

NOSE/THROAT? ☐ **Yes *(Specify Below)*** ☐ **No**

- ☐ Broken Nose: _____
- ☐ Difficulty Breathing: ☐ Right Nostril ☐ Left Nostril
- ☐ Sinus Infection/Congestion: _____
- ☐ Hoarseness: _____
- ☐ Difficulty Swallowing: _____
- ☐ Chronic Nose Bleeds: _____
- ☐ Nasal Allergies: _____
- ☐ Other: _____
- ☐ Sleep Apnea: _____
- ☐ Use of CPAP Machine: _____
- ☐ Snoring: _____
- ☐ Restricted Ability to Open Mouth: _____

ORAL problems? ☐ **Yes *(Specify Below)*** ☐ **No**

- ☐ Crowns / Caps: Where? _____
- ☐ Dentures / Bridges: _____
- ☐ Dental Implants: _____
- ☐ TMJ Problems/Pain: _____

EYES? ☐ **Yes *(Specify Below)*** ☐ **No**

- ☐ Wear Glasses: _____
- ☐ Wear Contacts: _____
- ☐ Eye Surgery (i.e., Lasik, Cataracts, etc.): _____
- ☐ Dry Eyes: _____
- ☐ Allergies / Itching Eyes: _____
- ☐ Excessive Tearing: _____
- ☐ Blood Shot Eyes: _____
- ☐ Glaucoma: _____
- ☐ Blurred Vision: _____
- ☐ Double Vision: _____
- ☐ Other: _____

MUSCULOSKELETAL problems? ☐ **Yes *(Specify Below)*** ☐ **No**

- ☐ Arthritis: ☐ Rheumatoid—Which joints? _____
  ☐ Osteo—Which joints? _____
- ☐ Pain/Numbness/Weakness of the Shoulders/Arms/Hands/Legs: _____
- ☐ Neck Stiffness/Pain: _____
- ☐ Restricted Neck Motion: _____
- ☐ Lower Back Pain: _____
- ☐ Joint Surgery/Replacement: _____
- ☐ Fibromyalgia: _____
- ☐ Foot Problems: _____
- ☐ Other: _____

NEUROLOGICAL problems? ☐ **Yes *(Specify Below)*** ☐ **No**

- ☐ Seizures: _____
- ☐ Epilepsy: _____
- ☐ Migraines: What is the trigger? _____
- ☐ Head/Brain Trauma / Concussion: _____
- ☐ Headaches: _____
- ☐ Stroke / Loss of Speech/Strength: _____
- ☐ Bells Palsy / Facial Paralysis: _____
- ☐ Fainting Spells: _____
- ☐ Other: _____

EMOTIONAL issues? ☐ **Yes** ***(Specify Below)*** ☐ **No**

☐ Anxiety Attacks: _____
☐ Claustrophobia: _____
☐ Depression: _____
☐ Difficulty Sleeping: _____
☐ Perfectionist: _____
☐ Psychological/Psychiatric Care: _____
☐ Bipolar Disorder: _____
☐ Other: _____

FAMILY HISTORY

Please list any diseases that run in your immediate family (i.e., Cancer, Diabetes, Heart Disease).

	Condition
Grandparents:	_____
Parents:	_____
Siblings:	_____
Children:	_____
Other:	_____

For WOMEN Only:

- Could you currently be pregnant? ☐ Yes ☐ No
- Number of pregnancies: _____ Number of children: _____
- Are you menopausal? ☐ Yes ☐ No
- Do you use birth control/hormone replacement? ☐ Yes ☐ No
  Type: _____
- Date of last mammogram: _____/_____/_____ Facility: _____
  Any abnormalities? _____
- Any breast lumps? ☐ Yes ☐ No
- Any nipple discharge? ☐ Yes ☐ No
- Any breast biopsies? ☐ Yes ☐ No
- Did you breast-feed your children? ? ☐ Yes ☐ No
- Your current bra size—Chest _____ Cup _____
- Breast Implants? ☐ Yes ☐ No
  - Size: _____
  - Manufacturer: _____
  - ☐ Submuscular ☐ Prepectoral

For MEN Only:

☐ History of Taking Anabolic Steroids
☐ Enlargement of Breast Tissue

Do you retain information best by: ☐ Listening ☐ Seeing ☐ Both

ANESTHESIA HISTORY

- Have you had any difficulties with anesthesia in the past? ☐ Yes ☐ No
- Types of anesthesia you have experienced in the past:
  - ☐ Local Anesthetics: Did you have any reactions/complications? _____
    _____
  - ☐ IV Sedation (i.e., during a colonoscopy): Did you have any reactions/complications? _____
    _____
  - ☐ General Anesthesia: Did you have any reactions/complications? _____
    _____
- Do you get motion sickness? ☐ Yes ☐ No
- Do you get nauseous after sedation/general anesthesia? ☐ Yes ☐ No
- Are you very sensitive to anesthetic medications? ☐ Yes ☐ No
- Family history of anesthetic complications (i.e., malignant hyperthermia, prolonged paralysis, etc.)? ☐ Yes ☐ No
- Does the dentist have difficulty numbing you? (i.e., multiple shots) ☐ Yes ☐ No

This is a summary of your medical history and will be kept in this office in a confidential manner.
At the time of your consultation, photos may be taken for documentation, or, to show you, in simulation, how your surgery outcome might appear. These images will also be maintained in a confidential manner and will not be used for educational or promotional purposes. **With your written permission only, protected health information may be:**
Forwarded to the surgery center should you have surgery with Dr. Kay, transmitted to your physician for medical clearance for surgery or Dr. Kay refers you to another practitioner.

Dr. Peter Kay is not a Medicare provider, nor a provider for any insurance company. You, as our patient may not submit a claim for any services received in our office. We will not be able to provide any codes or legally submit any insurance claims.

Do you give our office permission to discuss medical/financial information with another party? ☐ Yes ☐ No

If yes, please provide the following information:

Name: _____

Relationship to Patient: _____

Daytime Phone: (_____)_____-_____ Evening Phone: (_____)_____-_____

By signing below you agree to having filled out this form to the best of your knowledge.

Form completed by: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian

Signature: _____ Date: _____/_____/_____

ABOUT YOURSELF

This last section asks you questions that may seem unusual for your physician to ask. As our philosophy is "treating the whole person," this information helps us greatly in getting to know you better.

Please do not feel in any way obligated to complete any or all of these questions. We are, however, striving to provide the best care for you, which includes you as an individual.

We thank you for taking the time to answer these questions, and hope that you will appreciate the manner in which it helps us care for you while you are our patient.

Hometown: _____

State & Country You Spent Most Time in Growing Up: _____

College Attended: _____ Degrees: _____ Advanced Degrees: _____

Military Service & Rank Obtained—You: _____ Spouse: _____

Children's Names, Ages, & Interests: _____

Grandchildren's Names, Ages, & Interests: _____

Other: _____

Any Relatives in the Medical Field & Their Specialties: _____

Are You Affiliated with any Groups/Service Organizations? _____

Sports or Exercise Activities: _____

Spectator Sports Interests: _____

Hobbies/Interests: _____

Pets: _____

Music Interests: _____

Reading Interests: _____

Vacation Interests: _____

What Are Your Most Proud Achievements: _____

On What Subjects do You Have Strong Feelings: _____

Who Have You Seen For Skin Care: _____

Anything Else You Care to Share: _____

Additional Comments: _____

_____

_____

_____

Thank you for telling us about yourself.
We look forward to taking the best care of you that we can, and appreciate your confidence in us.

Perfection Plastic Surgery & Skin Care
Pursuing Perfection in all we do for you

2355 N. Wyatt Dr. Suite 111, Tucson, AZ, 85712

Office: (520) 323-7100 Fax: (520) 323-2228

Website: www.drpeterkay.com

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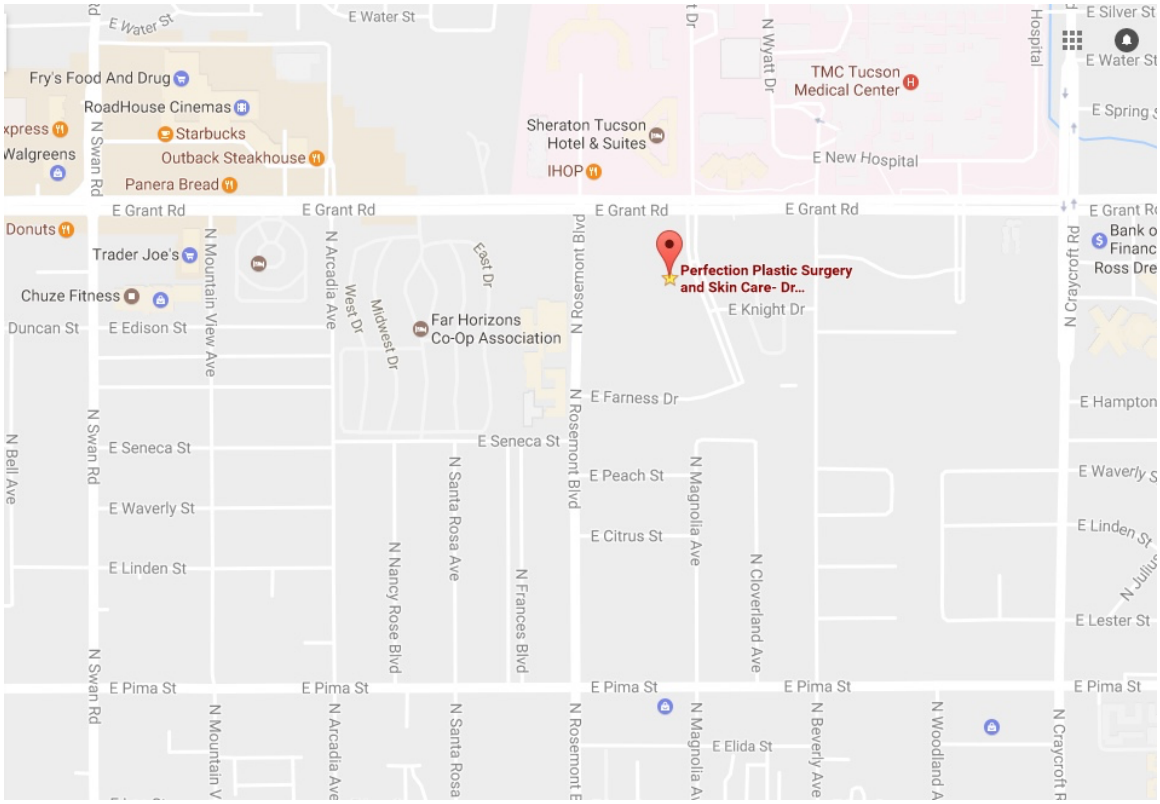

We are located at:
2355 N. Wyatt Dr. Suite 111, Tucson, AZ, 85712
South Side of Grant Road (Between Rosemont and Craycroft)
Just East of CVS Pharmacy
West of Wells Fargo Bank

Turn South on Wyatt Drive from Grant Road
2nd Building on your Right
Shared Parking Lot with MHC HealthCare