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!
COMPREHENSIVE SURGICAL HEALTH HISTORY

Name: ____________________________________________________________

Date of Birth: ________/_______/_______ Age: _______

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

Reason for consultation/Areas of concern: ________________________________________________________________

Local Address: ______________________________________________________________

Alternate Address (If Applicable) ☐ Same as above __________________________________________________________

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: __________________________________________

Employer: ____________________________________________________________

Occupation: __________________________________________________________

Work Phone: (______)______-________ Cell Phone: (______)______-________

Parent (If Patient is a Minor): ____________________________________________

Person to Contact in Case of an Emergency: __________________________________

Home Phone: (______)______-________ Cell Phone: (______)______-________

Your referral source: ____________________________________________________

Date: __________/________/________
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.

<table>
<thead>
<tr>
<th>Medications/Supplements</th>
<th>Dosage</th>
<th>How Often Taken</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

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

<table>
<thead>
<tr>
<th>Surgeries</th>
<th>Year</th>
<th>Surgeon &amp; Location</th>
</tr>
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<tbody>
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</table>

Primary Care Physician: ____________________________  Telephone #: ____________________________

Date of Last Physical Exam: _______ / _______ / _______

Any Other Specialists Who Take Care of You:

<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
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<tbody>
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</table>

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: ____________________________
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: ____________________________
  - 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: ____________________________

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**SKIN problems?**
- Excessive Sun Exposure: [ ]
- Skin Cancers: [ ]
- Skin Allergies/Sensitivities: [ ]
- Thick Scar Formation: [ ]
- Shingles: [ ]
- Cold Sores: [ ]
- Yes (Specify Below) [ ]
- No [ ]
- 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?**
- Chicken Pox: [ ]
- Mononucleosis: [ ]
- Herpes: [ ]
- Yes (Specify Below) [ ]
- No [ ]
- Hepatitis: [ ]
- MRSA: [ ]
- Other: [ ]

**EARS?**
- Hearing Loss: [ ]
- Hearing Aids: Right [ ] Left [ ]
- Ear Infections as a Child / Tubes: [ ]
- Yes (Specify Below) [ ]
- No [ ]
- Inner Ear Dizziness: [ ]
- Other: [ ]

**NOSE/THROAT?**
- Broken Nose: [ ]
- Difficulty Breathing: Right Nostril [ ] Left Nostril [ ]
- Sinus Infection/Congestion: [ ]
- Hoarseness: [ ]
- Difficulty Swallowing: [ ]
- Chronic Nose Bleeds: [ ]
- Yes (Specify Below) [ ]
- No [ ]
- Nasal Allergies: [ ]
- Other: [ ]
- Sleep Apnea: [ ]
- Use of CPAP Machine: [ ]
- Snoring: [ ]
- Restricted Ability to Open Mouth: [ ]

**ORAL problems?**
- Crowns / Caps: Where?: [ ]
- Dentures / Bridges: [ ]
- Dental Implants: [ ]
- TMJ Problems/Pain: [ ]
- Yes (Specify Below) [ ]
- No [ ]
- No Other: [ ]

**EYES?**
- Wear Glasses: [ ]
- Wear Contacts: [ ]
- Eye Surgery (i.e., Lasik, Cataracts, etc.): [ ]
- Dry Eyes: [ ]
- Allergies / Itching Eyes: [ ]
- Excessive Tearing: [ ]
- Yes (Specify Below) [ ]
- No [ ]
- Blood Shot Eyes: [ ]
- Glaucoma: [ ]
- Blurred Vision: [ ]
- Double Vision: [ ]
- Other: [ ]

**MUSCULOSKELETAL problems?**
- Arthritis: [ ] Rheumatoid—Which joints? [ ]
  Osteo—Which joints? [ ]
- Pain/Numbness/Weakness of the Shoulders/Arms/Hands/Legs: [ ]
- Neck Stiffness/Pain: [ ]
- Restricted Neck Motion: [ ]
- Yes (Specify Below) [ ]
- No [ ]
- Lower Back Pain: [ ]
- Joint Surgery/Replacement: [ ]
- Fibromyalgia: [ ]
- Foot Problems: [ ]
- Other: [ ]

**NEUROLOGICAL problems?**
- Seizures: [ ]
- Epilepsy: [ ]
- Migraines: What is the trigger? [ ]
- Head/Brain Trauma / Concussion: [ ]
- Headaches: [ ]
- Yes (Specify Below) [ ]
- No [ ]
- 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).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Grandparents:</th>
<th>Parents:</th>
<th>Siblings:</th>
<th>Children:</th>
<th>Other:</th>
</tr>
</thead>
</table>

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

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