Fax: 412.226.5176

Dr. Paul L. Leong
PATIENT MEDICAL HISTORY

Name:_____ Age: _____ Appt. Date:

Address:

City: _____ State: _____ Zip Code: _____

Email:_____Date of Birth:_____

Phone Number: Home (_____)_____Cell (_____)_____

Social Security #_____ Sex: Male:_____ Female:_____

☐ Would you like to receive emails about future news, events, special offers, treatment follow up emails and appointment reminder emails? Yes Please do not contact

☐ Would you like to receive appointment reminders via text message in the future? Yes No

If yes, please select Phone Carrier: □ Verizon □ AT&T □ Sprint □ Cricket □ T-Mobile □ Other

_____

How did you hear about us?

Referral

Straka & McQuone MD, Inc
Esthetic Dentistry Pittsburgh
Remington Orthodontics
Other Practice _____

Web

Sistine Facial Plastic & Laser Surgery Website
Vitals.com
Realself.com
Locateadoc.com
Yelp.com
Ratemd.com
Angieslist.com
Other website _____

E-mail

Sistine Facial Plastic email blast

Referred by physician

_____

Referred by current patient

_____

Other *(Please specify)*

_____

Reason for your visit today:

_____

_____

Please check any services that you may also be interested in:

Facial Plastic Surgery

Facelift
Mini facelift
Rhinoplasty (nose job)
Eyelid lift
Browlift
Mole Removal
Hair Transplantation
Earlobe Repair
Otoplasty (Ear Pinning)

Injectables/Laser

Botox Cosmetic
Dysport
Restylane/Perlane
Juvederm
Sculptra
Laser Hair Removal
Laser Skin Rejuvenation
Cortex Co2 &/or Erbium Laser

Non-surgical Innovations

Botox Browlift
Hand Rejuvenation
Lip Augmentation
Non-Surgical Rhinoplasty
Latisse Eyelash Enhancer
Ultherapy
Tear Trough Correction

Skin Care

Medical grade skin care
Chemical Peels
Make-up consultation

Other (please specify): _____

Are there any other areas of concern you would like to speak with Dr. Leong about (please check below):

θ	Skin care advice	θ	Facial veins	θ	Receding hairline
θ	Skin care products	θ	Facial redness	θ	Nasal breathing
θ	Facial fine lines	θ	Liver spots/age spots	θ	_____
θ	Facial wrinkles	θ	Neck/facial laxity	θ	_____
θ	Facial folds	θ	Brow position	θ	_____
θ	Thin lips	θ	Drooping eyelids		
θ	Blotchy skin	θ	Nose		
θ	Lack of or Sparse eyelashes	θ	Facial fullness		

Insured Information *(NON-COSMETIC ONLY)*

Name_____ Relationship to patient_____

Address_____

Social Security #_____ Phone (_____)_____

Employer_____ Phone (_____)_____

Insurance Company_____ ID#_____

In case of an emergency, Please provide us with the name, phone number and relationship of the nearest relative not living with you. Name: _____

Phone: _____ Relationship _____

Family Physician Name: _____ Phone:

Family Physician Address:

Please give us the name of someone with whom we may release any of your medical information to

and their relationship to you_____

List any medical conditions for which you are presently being treated:

Have you had an allergic reaction to any of the following?

Penicillin (please explain nature of reaction: _____)

Lidocaine (please explain nature of reaction: _____)

Eggs (please explain nature of reaction: _____)

List all other **Allergies** drugs/food/tape (please explain nature of reaction if any):

No Known Allergies

Have you ever had dental anesthesia (Novacaine)? Yes No Any bad reaction? Yes No

List all current medications (by mouth and topical) including prescription, over-the-counter, vitamins, herbal supplements and creams:

MEDICATION	DOSAGE & FREQUENCY	HOW LONG HAVE YOU TAKEN

* Currently **not** taking any medications (by mouth and topical) including prescription, over-the-counter, vitamins, herbal supplements and creams.

Do you take birth control pills? Yes No if yes, name:

Are you or have you recently taken any Aspirin containing medication? Yes No

Do you take any blood thinners? Yes No If yes, name(s): _____

Do you have any history of skin cancer? Yes No If yes, location and type:

Have you been on Accutane therapy in the last 24 months? Yes No

Have you taken any steroid preparations over the past year? Yes No

Have you had significant weight change in the past year? Yes No ____ lbs loss ____ lbs gain

Height: _____ Current Weight: _____

Do you use sunscreen? (circle one) Always Sometimes Never

Do you smoke? (circle one) Always Sometimes Never Previous Smoker

Do you drink alcohol? (circle one) Always Sometimes Never

List all past surgeries (including cosmetic surgery) with dates:

* No past surgeries (including cosmetic surgery)

Have you ever had any surgical complications? Yes No

If yes, please describe:

Do you faint easily? Yes No

FOR FEMALES

Are you currently pregnant? Yes No If no, are you planning to become pregnant? Yes No

Are you currently nursing? Yes No

FAMILY HISTORY

Check the following medical conditions that have occurred in your family (current or past):

DISEASE	MOTHER	FATHER	BLOOD RELATIVE
Allergies			
Arthritis			
Asthma			
Breast Cancer			
Cancer			
Diabetes			
Eczema			
Heart Disease			
High Blood Pressure			
Lung Disease			
Psoriasis			
Skin Cancer			
Tuberculosis			
Other skin condition			

Please check all past and present medical conditions:

CARDIOVASCULAR:

High blood pressure
Heart attack(s)
Pacemaker
Coronary artery disease
Heart murmur/Mitral valve prolapse
Irregular heartbeat/palpations
Other

PULMONARY:

Asthma
Chronic lung disease
Chronic cough
Shortness of breath
Other:

HERMATOLOGY:
Blood transfusion
Bleeding disorder
Other:

NEUROMUSCULAR:
Arthritis
Muscle weakness
Nerve damage
Facial paralysis/weakness
Headaches
Seizure disorder/convulsions

PSYCHOLOGICAL:
Depression
Anxiety
Claustrophobia
Receive(d) psychiatric treatment
Drug/alcohol dependency treatment
Psychiatric hospitalization
Other:

EARS/NOSE/THROAT:
Nasal allergies
Difficulty breathing by nose
Previous nasal injury
History of sinus infections
Hearing difficulty
Hoarseness
Other:

EYES:
Dry eye
Blurred/double vision
Cornea problems
Glaucoma
Thyroid eye disease
Wear glasses/contacts
Other:

ENDOCRINE:

Diabetes
Thyroid disease
Lupus
Other:

HEPATIC:
Hepatitis
Pancreatitis
Cholecyctitis
Other:

RENAL:
Renal failure
Dialysis
Other:

GASTROINTESTINAL:

Colitis
Reflux disease
Stomach ulcers
Other:

Spinal/back disorders

DERMATOLOGICAL:
Acne
Rosacea
Excessive sweating
Eczema
Psoriasis
Radiation to face/neck
Scarring/keloid formation
Other:

Anything not listed above:

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I _____ understand that a copy of our offices Notice of Privacy Practices is available upon request.

_____ _____
Signature of Patient Date

HIPAA is an acronym for the Health Insurance Portability and Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification Section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information except appointment confirmation by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you would like to have the information released to someone other than yourself please complete the following:

I authorize the doctor's office to leave medical information pertaining to my care by the following methods and will assume

responsibility to notify them, in writing, whenever this information changes.

Home telephone	yes _____ no _____	Voice mail	yes _____ no _____
Answering machine	yes _____ no _____	Cell phone/voice mail	yes _____ no _____
Work phone	yes _____ no _____	Cell phone carrier:	□ Verizon □ AT&T □ Sprint □ Cricket
Pager	yes _____ no _____		

May we fax medical records for referrals? yes _____ no _____

Please list names of people we can discuss your medical or skin care with:

Spouse Name: _____ yes _____ no _____
Parent Name: _____ yes _____ no _____
Other Name: _____ yes _____ no _____
Please give name and relationship such as boyfriend, sister, etc.

Anytime we receive a call from yourself or those that you have listed as individual(s) that may discuss your medical or skin care records they will have to supply a unique identifier that confirms identity. Please list your unique identifier as either the last four digits of your social security number or your mother's maiden name:

Unique Identifier: (select one)

- □ **Last four digits of SS#** _____
- □ **Mother's maiden name** _____

_____ _____
Signature of Patient/Guardian Date