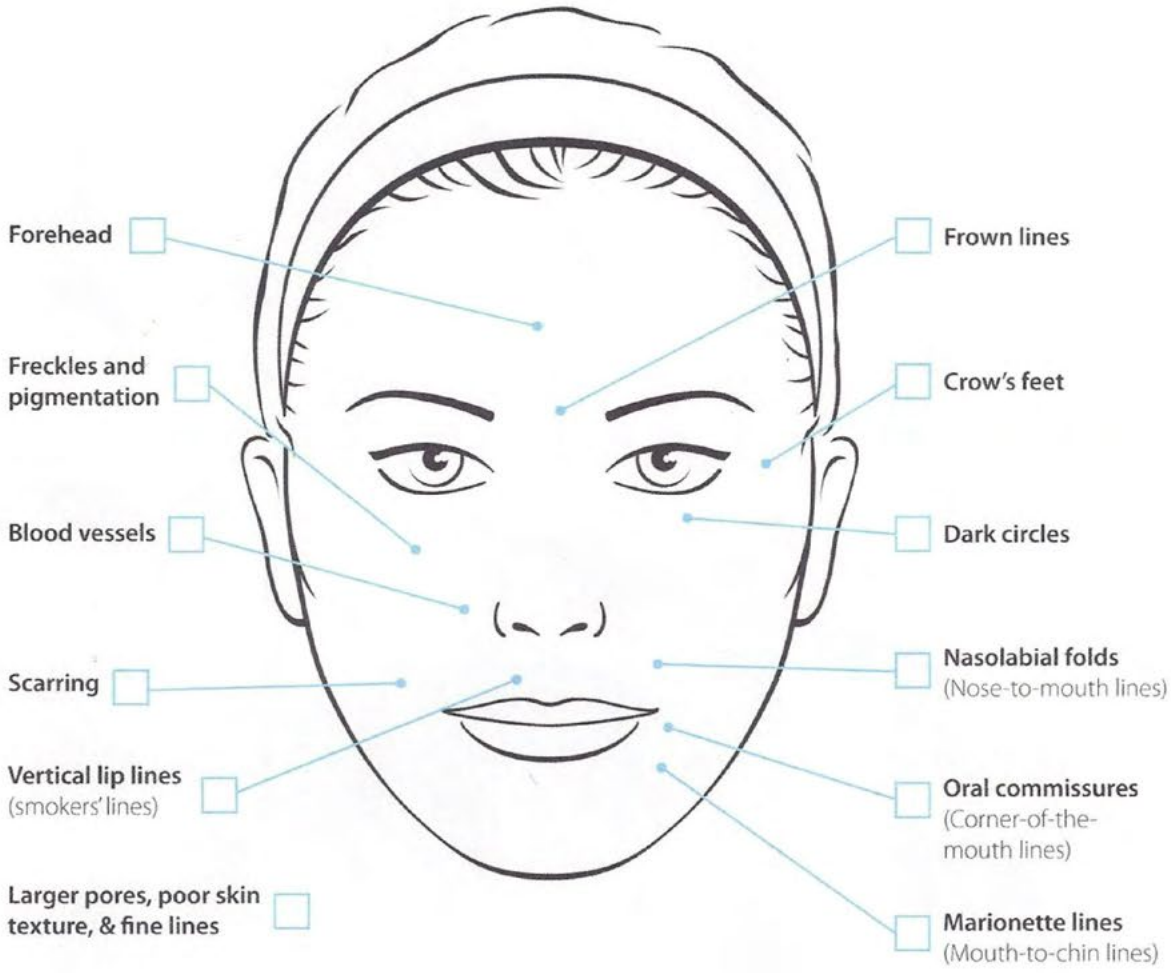
Patient Forms

doctor B

BÜLENT CİHANTİMUR

Anatomical Face Map

With respect to facial aesthetics, please mark those areas of the face that bother or trouble you. In the boxes provided please rate these areas on a scale of 1 to 5 (1 being least bothersome, 5 being most bothersome). Feel free to draw on the chart to identify any other facial concerns.



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Skin Care Questionnaire

SkinCare

What are your current skincare concerns?

What skin care treatments or procedures have you had in the past?

If you've had previous skin care treatments were you pleased with the outcome? ☐Yes ☐No (If no, why were you dissatisfied)

Please circle 3 things you would like to improve about your skin.

Lines Wrinkles Rough Texture Dull Pores Blotchiness Dry & Tight Age Spots Breakouts Oiliness Prevention

Do you have sensitive skin, occasional or recurring skin problems we should be aware of? ☐Yes ☐No (If yes, please explain)

Have you ever experienced allergic reaction to skin products? ☐Yes ☐No (If yes, please explain)

Are you currently using any skin lightening products (e.g. Retin A or Hydroquinone)? ☐Yes ☐No (If yes, what products?)

List your current skincare routine. List the brand names next to the products used.

		Brand Name
Cleanser(s)	☐Yes ☐No	
Exfoliation	☐Yes ☐No	
Serum/Hydration	☐Yes ☐No	
Toner	☐Yes ☐No	
Moisturizer	☐Yes ☐No	
SPF/Sunscreen	☐Yes ☐No	
Masks	☐Yes ☐No	
Eye Gel/Creams	☐Yes ☐No	
Retin-A or similar product	☐Yes ☐No	

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Patient Information

Today's Date: _____

Welcome As a new patient, please fill out the information found below to the best of your ability. Please answer these health and beauty related questions to help us design the ideal experience for you. All information will remain confidential.

Name:_____ **Birthday:**____/____/_____ **Age:** _____
last first middle

Responsible Party (if minor) :_____ **Height** _____ **Weight:** _____

Mailing Address:_____

City:_____ **State/Country:**_____ **Zip:**_____

Telephone: Home _____ **Work** _____ **Cell** _____

Primary Email Address: _____ ☐ *I would like to receive promotions & news via e-mail*

Sex: ☐Female ☐Male **Marital Status:** ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

How did you hear about
☐ TV ☐ Internet ☐ Magazine ☐ Newspaper ☐ Other/Define _____ Referred by _____ ☐ patient

Preferred method for confirming appointments: ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email

Patient Employed by: _____
Address: _____
Occupation: _____ Business Phone _____
Work Email: _____

Spouse or Responsible Party Name: _____
Address: _____
Occupation: _____ Business Phone _____
Work Email: _____

Please check all of surgical and non-surgical procedures that interest to you.

FACE
- ☐ Facelift, Neck Lift, Brow Lift
- ☐ Eyelid Surgery
- ☐ Nose Surgery (cosmetic and breathing)
- ☐ Lip Surgery
- ☐ Facial Contouring, Implants, Fat Grafting
- ☐ Prominent Ear
- ☐ Other _____

BREAST
- ☐ Breast Augmentation
- ☐ Breast Revision/Reconstruction
- ☐ Breast Lifts
- ☐ Breast Reduction
- ☐ Scar Revisions
- ☐ Nipple Surgery
- ☐ Other _____

BODY
- ☐ Surgical Body Contouring Fat Reduction
- ☐ Tummy Tucks
- ☐ Hernia
- ☐ Body Lift, Arm Skin Reduction
- ☐ Scar Revisions (e.g., C-Sections)
- ☐ Labia Contouring/Reduction
- ☐ Other _____

MEDSPA
- ☐ Botox or Dysport Injections
- ☐ Dermal Fillers (e.g.,Restylane, Juvederm)
- ☐ Lip Enhancements
- ☐ CoolSculpting Non-Surgical Fat Reduction
- ☐ Laser Hair Removal
- ☐ Laser Treatments to Improve Skin Quality
- ☐ Laser Therapy to Improve Pigmentation or Spots
- ☐ Laser Therapy for Skin Tightening or Firming
- ☐ Medical Facials and Peels
- ☐ Anti-Aging, Prevention Skincare
- ☐ CellCeuticals Skin Care by Garth Fisher, MD
- ☐ VISIA Skin Analysis
- ☐ Microdermabrasion (Dermasweep vitamin infused facial)
- ☐ Sun Damage Repair
- ☐ Acne Treatments
- ☐ Scar Treatment
- ☐ Eyelash Enhancement
- ☐ Nutrition & Wellness
- ☐ Not sure, need consultation
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

PERSONAL PHYSICIAN
Name: _____ Phone: _____ Address: _____

EMERGENCY CONTACT
Name: _____ Phone: _____ Relationship_____

INSURANCE
Name of Insurance Provider _____ Primary Insurer _____
Contract # _____ Group # _____

ASSIGNMENT AND RELEASE
I, the undersigned, have insurance coverage with the company named above.
I assign, directly to Dr. Cihantimur , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, includi g possible hospitalizations, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

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Patient Name :_____

For your safety and well-being, we would like you to answer a few health-related questions. This information will remain confidential.

Past and/or Current Med Spa Service History: (Please circle and date last known service)

Facials	Laser Hair Removal	Injections (Botox/Dysport)	Fractional Laser Therapy
Chemical Peels	IPL /Photo Facial	Dermal Fillers (Restylane/ Juvederm)	
Microdermabrasion		Vein Therapy	VISIA Skin Analysis

Patient Social History: (Please circle applicable choice)

Use of alcohol	Never	Rarely	Moderate	Daily
Use of tobacco	Never	Previously, but quit	Current: packs/day	
Dietary sugar intake	Minimal	Moderate	Much	Excessive
Sun Exposure	Never	Rarely	Moderate	Daily Work in the Sun
Tanning Beds	Never	Rarely	Moderate	Daily

Female Patients Only: (Please circle applicable choice)

Is your menstrual period regular	Yes	No	Have you had a hysterectomy	Yes	No
Are you currently pregnant or is there any possibility you might be	Yes	No	Currently Breastfeeding	Yes	No
Currently taking oral contraceptives	Yes	No	Planning on becoming pregnant in the near future	Yes	No
Is your menstrual period due in the next week	Yes	No	Are you currently sexually active	Yes	No
Hormone imbalance	Yes	No			

Past and/or Current Medical History: (Please circle applicable choice)

Heart Disease	Eczema	Hepatitis	Epilepsy	Cancer
Diabetes	Varicose Veins	Asthma	Stroke	Family History of Skin Cancer
High/Low Blood Pressure	HIV	Thyroid Problems	Depression	Nervousness
Allergies	Implants	Hysterectomy	Insomnia	*Accutane*
Fever Blister, Cold Sores, Shingles, Oral Herpes	Retin A/Retinol Creams	Use of Gold Therapy	Other:	

General Health and Skin Wellness History: (Please circle applicable choice)

Contacts	Yes	No	Any problems healing from a cut or burn	Yes	No
Do you wear sunglasses daily	Yes	No	Any facial waxes used in the past 3 weeks	Yes	No
Around secondary smoke	Yes	No	Any facial depilatories used in the past 3 weeks	Yes	No
Do you live in an urban environment	Yes	No	Air travel (frequent)	Yes	No
Do you spend a lot of time in the sun	Yes	No	Do you ever experience breakouts	Yes	No
Any dental work in the last 6 months	Yes	No	Take vitamins or supplements	Yes	No
Serious illness in past 6 months	Yes	No	Do you get a regular physical exam	Yes	No
Recent weight gain or loss	Yes	No	Exercise regularly	Yes	No
Overall healthy diet	Yes	No			

On average, how many glasses of pure water do you drink every day? _____

Please rate your average stress level on a scale from 1-10:_____ (1 is "lowest" and 10 is "highest")

I certify that the above is true, correct and complete. I am aware and accept that withholding information about my medical history could result in serious injury to me or harm to those involved in my care. I am aware that providing false or incomplete information about my medical and surgical history may result in the cancellation of my proposed surgical procedure and also result in forfeiture of my surgical fees.

_____ _____

patient signature date

Patient Name :_____

ALLERGIES AND SENSITIVITIES

Check Yes or No the box if you have a history of skin reaction or other illness following contact with:

YES NO

- ☐ ☐ Penicillin, Sulfa or other antibiotic
- ☐ ☐ Morphine, Codeine, Demerol or narcotic
- ☐ ☐ Novocain, Lidocaine or local anesthetics
- ☐ ☐ Tetanus toxoid or serums
- ☐ ☐ Adhesive tape
- ☐ ☐ Iodine, Betadine, Chlorhexidine or Phisohex
- ☐ ☐ Tincture of Benzoin
- ☐ ☐ Latex rubber

List other drug, medicine or other substance here:

DRUGS AND MEDICINES

Check Yes or No the box if you have taken any of the following within the **last 6 months:**

YES NO

- ☐ ☐ Cortisone, prednisone or ACTH
- ☐ ☐ Diuretics or water pills
- ☐ ☐ Blood pressure medication
- ☐ ☐ Steroids or body building drugs
- ☐ ☐ Seizure medication
- ☐ ☐ Insulin or diabetes medication
- ☐ ☐ Headache or migraine medications
- ☐ ☐ Asthma medication
- ☐ ☐ Heart medication
- ☐ ☐ Anticoagulants or blood thinners
- ☐ ☐ Pain pills
- ☐ ☐ Appetite suppressants or diet pills
- ☐ ☐ "Fen-Phen," Redux, Pondimin, phentermine or fenfluramine
- ☐ ☐ Sedatives, tranquilizers or sleeping pills
- ☐ ☐ Antidepressants, antipsychotics or nerve pills
- ☐ ☐ Recreational or illegal drugs
- ☐ ☐ Homeopathic or herbal medicines (list below)

MEDICATIONS THAT CAUSE BLEEDING

Do you regularly take any of the following:

YES NO

- ☐ ☐ Aspirin or aspirin-containing medications
- ☐ ☐ Ibuprofen (Motrin, Advil & Nuprin)
- ☐ ☐ Ketoprofen (Aleve)
- ☐ ☐ Vitamin E (excluding E in multivitamin)
- ☐ ☐ Anti-inflammatories or muscle relaxants

List ALL drugs or medications **currently** used:

SURGERY

Check Yes or No the box for each question:

YES NO

- ☐ ☐ Abnormal healing or poor scar hformation
- ☐ ☐ Adverse or unusual reaction to surgery
- ☐ ☐ Abnormal bleeding
- ☐ ☐ Do you know of any reason you should not undergo surgery and anesthesia

IMPORTANT MEDICAL CONDITIONS

Check Yes or No the box if you have been diagnosed or ever received treatment for any of the following:

YES NO

- ☐ ☐ Anaphalaxis or severe allergy attack
- ☐ ☐ Migraines, headaches or chronic head pain
- ☐ ☐ Chronic fatigue syndrome
- ☐ ☐ Seizures
- ☐ ☐ Strokes
- ☐ ☐ Glaucoma
- ☐ ☐ Cataracts or cataract surgery
- ☐ ☐ Lasik or laser vision correction
- ☐ ☐ Stiff neck
- ☐ ☐ Back problems
- ☐ ☐ Artificial joint replacement
- ☐ ☐ Bell's palsy or neurological problems
- ☐ ☐ Asthma, TB, emphysema or chest disease
- ☐ ☐ Pneumonia
- ☐ ☐ Pulmonary embolus
- ☐ ☐ High blood pressure
- ☐ ☐ Heart attack, angina, palpitations or irregular heartbeats
- ☐ ☐ Rheumatic fever or congenital heart disease
- ☐ ☐ Chest pain or angina
- ☐ ☐ Shortness of breath, dizziness or fainting
- ☐ ☐ Ankle swelling
- ☐ ☐ Angioedema, persistent or unusual swelling
- ☐ ☐ Pacemaker
- ☐ ☐ Artificial heart valve
- ☐ ☐ Mitral valve prolapse
- ☐ ☐ Poor circulation, leg ulcers or peripheral vascular disease
- ☐ ☐ Splenectomy (removal of spleen)
- ☐ ☐ Phlebitis, blood clots or varicose veins
- ☐ ☐ Ulcer disease
- ☐ ☐ Pancreatitis
- ☐ ☐ Inflamatory bowel disease or bowel problems
- ☐ ☐ Gastro esophageal reflux
- ☐ ☐ Hepatitis, jaundice, cirrhosis or liver disease
- ☐ ☐ Blood transfusion
- ☐ ☐ HIV or AIDS
- ☐ ☐ Anemia or blood disorder
- ☐ ☐ Frequent nosebleeds or heavy menstrual periods
- ☐ ☐ Easy bruising
- ☐ ☐ Diabetes
- ☐ ☐ Thyroid problem or Graves' disease
- ☐ ☐ Kidney failure, kidney or prostate problems
- ☐ ☐ Lupus, arthritis or autoimmune disease
- ☐ ☐ X-Ray treatments or radiation therapy
- ☐ ☐ Severe snoring or sleep apnea
- ☐ ☐ Sleep disorder

DENTURES

- ☐ ☐ Capped teeth, bridges or veneers
- ☐ ☐ Loose teeth or gum disease
- ☐ ☐ Other oral/dental problems

ANESTHESIA

- ☐ ☐ Adverse or unusual reaction to anesthesia
- ☐ ☐ Do you have a blood relative who had anesthesia complications of any kind

ADDITIONAL MEDICAL CONDITIONS

Check Yes or No the box if you have been diagnosed or ever received treatment for any of the following:

YES NO

- ☐ ☐ Alcohol abuse or alcoholism
- ☐ ☐ Drug abuse or addiction
- ☐ ☐ Psychological or emotional problems
- ☐ ☐ Depression
- ☐ ☐ Personality disorder
- ☐ ☐ Bipolar or manic depressive illness
- ☐ ☐ Schizophrenia
- ☐ ☐ Nervous breakdown
- ☐ ☐ Claustrophobia or panic attacks
- ☐ ☐ Body Dismorphic Disorder (BDD)
- ☐ ☐ Eating disorder, anorexia or bulimia
- ☐ ☐ Currently in therapy or counseling
- ☐ ☐ Currently confused, depressed or having suicidal thoughts
- ☐ ☐ Is there violence in your home?
- ☐ ☐ Is anyone threatening you or making you feel bad about yourself?
- ☐ ☐ Is there someone close to you, or are there members of of your family who strongly object to your having plastic surgery?

List **other medical conditions** here:

List all previous **surgical procedures** you have undergone & approximate date(s):

I certify that the above is true, correct and complete. I am aware and accept that withholding information about my medical history could result in serious injury to me or harm to those involved in my care. I am aware that providing false or incomplete information about my medical and surgical history may result in the cancellation of my proposed surgical procedure and also result in forfeiture of my surgical fees.

_____ _____ _____ _____

patient signature date witness signature date