Bahman Guyuron, M.D., F.A.C.S.
Zeeba Clinic
29017 Cedar Road
Lyndhurst, OH 44124
440-646-2173

Attached you will find demographic and medical information forms. It is **very important** that you fill out this paperwork **in its entirety** (do not leave pages blank) and bring with you to your appointment.

Please note – If you are unable to keep your scheduled appointment, call the office a minimum of 24 hours ahead to cancel or reschedule that appointment. Failure to cancel your appointment without 24 hours notice will result in a $75 cancellation/no-show fee.

Thank you for completing this information. We look forward to seeing you.

INFORMATION FOR CASE HISTORY FILE

(PLEASE complete all items, PLEASE print or type)

Today's Date_____

Mrs. □ Miss □ Mr. □ Ms. □ Married □ Single □ Divorced □ Separated □ Widowed □ SS#_____

Patient's Name_____ Age_____ Date of Birth_____

Home Phone_____ Cell_____Work_____ Prefer: H□ C□ W□

Address_____

City_____ State_____ Zip_____

Email_____

Patient's Occupation_____Employer_____

Business Address_____ City_____ State_____ Zip_____

Spouse Name_____ Spouse Occupation_____

Referred by_____ Address_____

City_____ State_____ Zip_____ Phone_____

****

Insurance Company_____ Address of Insurance Company_____

Policy Number_____ Subscriber's Name_____

Birth date of subscriber_____ SS # of subscriber_____

Group number_____ Employer_____

****

Specific problem(s) for which you are seeking plastic surgery:_____

Have you consulted any other doctors, including plastic surgeons, about this? No_____ Yes_____

If yes, please list their name(s):_____

Release of Information

May we leave a message at your home with other residents? Yes_____ No____

May we leave a message on your answering machine/voice mail? Yes_____ No____

Whom may we speak with about your medical concerns?

Name: _____Relationship: _____Phone No. _____

Emergency Contact_____Relationship_____Phone_____

Can they be contacted about your general care? Yes_____ No____

FAMILY HISTORY

Fill in the following information about your family

Check if any of your relatives have had the following:

Relation	Age	State of Health	Age at Death	Cause of Death		Disease	Relationship To You
Father						Diabetes	
Mother						Heart Disease	
Brothers						Cancer	
						High Blood Pressure	
						Stroke	
						Arthritis	
Sisters						Asthma	
						Chemical Dependency	
						Kidney Disease	
						Other	

MEDICATIONS, DRUGS

Are you allergic to any medicines? ☐ **No** ☐ **Yes**

If "Yes," which one(s)? _____

Please list ALL of your medications and their dosages (including VITAMINS, BIRTH CONTROL PILLS, DIURETICS (water pills), BLOOD PRESSURE or HEART MEDICATIONS, TRANQUILIZERS, HORMONES, BLOOD THINNERS, NOSE DROPS and SPRAYS, INHALER MEDICINES, RUB-ON MEDICATIONS (liniments), ASPIRIN, BUFFERIN, ETC.)

_____ _____

_____ _____

_____ _____

PAST MEDICAL HISTORY

General Health: ☐ **Good** ☐ **Fair** ☐ **Poor**

If not "Good," please explain:

_____

Height_____ **Weight**_____ **Weight loss or gain in past year** _____**lb.** ☐**Loss** ☐**Gain**

How long ago was your most recent physical check-up? _____

Name and address of the doctor _____

(Name) **(Address)**

Did it include an electrocardiogram? ☐ **No** ☐ **Yes**

Did it include a chest X-ray? ☐ **No** ☐ **Yes**

History of Raynaud's Disease or Cold Intolerance? ☐ **No** ☐ **Yes** _____

Serious Illnesses (Please List) _____

_____

_____

_____

Previous Surgery (Please List)

Operation	Year	Hospital	City	Surgeon's Name	Anesthesia (Local or General)

Have you had significant complications or aftereffects from any of these operations? ☐ **No** ☐ **Yes**

If "Yes,"
Please explain: _____

_____

_____

_____

_____

INJURIES

Type of Injury	Year	Hospital	Doctor	After-Effects

SOCIAL HISTORY

What is your approximate daily consumption of the following: Coffee/Tea _____ cups per day / week / month?

Alcohol _____ drinks per day / week / month Tobacco _____ # of times per day

Are there other smokers in the house? ☐ **No** ☐ **Yes How much?** _____

Other intoxicating or mind altering drugs (specify): _____

PREOPERATIVE INFORMATION

Have you ever reacted badly to being put to sleep for surgery?	☐ No ☐ Yes
Has any member of your family ever reacted badly to being put to sleep for surgery?	☐ No ☐ Yes
Have you required unusually large amounts of local anesthetic for medical or dental procedures?	☐ No ☐ Yes
Have you ever had a bad reaction to a local anesthetic (Novocain, etc.)?	☐ No ☐ Yes
Are you allergic to adhesive tape?	☐ No ☐ Yes
Do you have high blood pressure?	☐ No ☐ Yes
Have you ever had scarlet fever or rheumatic fever?	☐ No ☐ Yes
Do you bleed unusually easily (from cuts, surgery, or tooth extractions)?	☐ No ☐ Yes
Are you a slow or poor healer?	☐ No ☐ Yes
Do you form large scars or keloids?	☐ No ☐ Yes
Do you have any skin disease, hives, eczema, or rash?	☐ No ☐ Yes
Do you have frequent infections or boils?	☐ No ☐ Yes
Have you taken steroid medications, cortisone, or ACTH?	☐ No ☐ Yes
Do you have shortness of breath with walking?	☐ No ☐ Yes
Do you have, or have you had any back trouble?	☐ No ☐ Yes
Does your religion prohibit blood transfusions?	☐ No ☐ Yes
Do you have, or have you had any significant emotional problems?	☐ No ☐ Yes
Have you ever been advised to seek psychiatric care?	☐ No ☐ Yes

Have you had any illnesses or disorders of the following? (Check if Yes)

☐ **Brain (including strokes, epilepsy)**	☐ **Face (including paralysis)**	☐ **Heart or blood vessels**
☐ **Blood**	☐ **Arms or Legs**	☐ **Bones or Joints**
☐ **Nervous System**	☐ **Nose, Sinuses, Throat**	☐ **Stomach**
☐ **Urinary System**	☐ **Eyes (including glaucoma, dryness)**	☐ **Breasts**
☐ **Intestines**	☐ **Reproductive System**	☐ **Endocrine System (diabetes)**
☐ **Ears**	☐ **Lungs (including asthma)**	☐ **Liver**

If "Yes,"
Please explain: _____

_____

_____ _____ _____

Patient/Guardian Signature **Relationship to Patient (Self, Mother, etc.)** **Date**

Guyuron Clinic, LLC.

General Consent for Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information: Your protected health information will be used or disclosed by **Guyuron Clinic, LLC.** for the purposes of treatment, obtaining payment, or day-to-day operations of the practice.

Notice of Privacy Practices: You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. Please review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information: You may request a restriction on the use or disclosure of your protected health information.

Guyuron Clinic, LLC. reserves the right to allow or restrict the use or disclosure of your protected health information.

If **Guyuron Clinic, LLC.** agrees to your request restricting the use of your PHI it will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction is a violation of the federal privacy standards.

Revocation of Consent: You may revoke this consent to the use and disclosure of your protected health information. You must request a revocation in writing. Any use or disclosure prior to the date your revocation is received will not be affected.

Reservation of Right to Change Privacy Practices: **Guyuron Clinic, LLC.** reserves the right to modify the practices outlined herein.

I have reviewed this consent form and give permission to **Guyuron Clinic, LLC.** to use and disclosure my health information in accordance with it.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

PHOTOGRAPHIC RELEASE AND CONSENT

BAHMAN GUYURON, M.D., F.A.C.S.

I understand that photographs will be taken during my visit. I accept that I may be recognized from my likeness or case history. Nevertheless, I authorize my plastic surgeon to use my photographs, videotapes and case information in the settings that I have checked:

- ❑ Lectures and multi-media presentations for an audience of medical professionals
- ❑ Medical, surgical, and scientific journal articles and publications
- ❑ My surgeon's file of pre and postoperative patient photographs available to prospective patients for viewing in the office
- ❑ For office and surgical use only
- ❑ Newspaper and magazine articles in which my surgeon participates
- ❑ Television programs in which my surgeon participates
- ❑ My surgeon's personal web site or web page
- ❑ My surgeon's personal social media sites: Facebook, Twitter, Instagram, etc.
- ❑ Lectures and multi-media presentations given by my surgeon for the general public
- ❑ For use by the ABPS (American Board of Plastic Surgery)

I also authorize my plastic surgeon's professional association, the not-for-profit American Society for Aesthetic Plastic Surgery, to use my photographs and case information in fulfilling its mission of public education, in the settings that I have checked:

- ❑ Patient education brochures available for purchase
- ❑ Educational video tapes available for purchase
- ❑ Lectures and slide presentations available for purchase
- ❑ Information submitted by the Society to consumer periodicals and magazines for publication
- ❑ Television programs about plastic surgery
- ❑ Case studies presented on the Society's web site at www.surgery.org

_____

Patient Signature Date

_____

Print Name

The consent provided in this document shall be valid immediately and until such time as the patient affirmatively withdraws, in a writing addressed to Bahman Guyuron, M.D., F.A.C.S. the consent provided herein. Such withdrawal shall be effective upon its receipt by Bahman Guyuron, M.D., F.A.C.S