# McCollough Plastic Surgery Clinic*

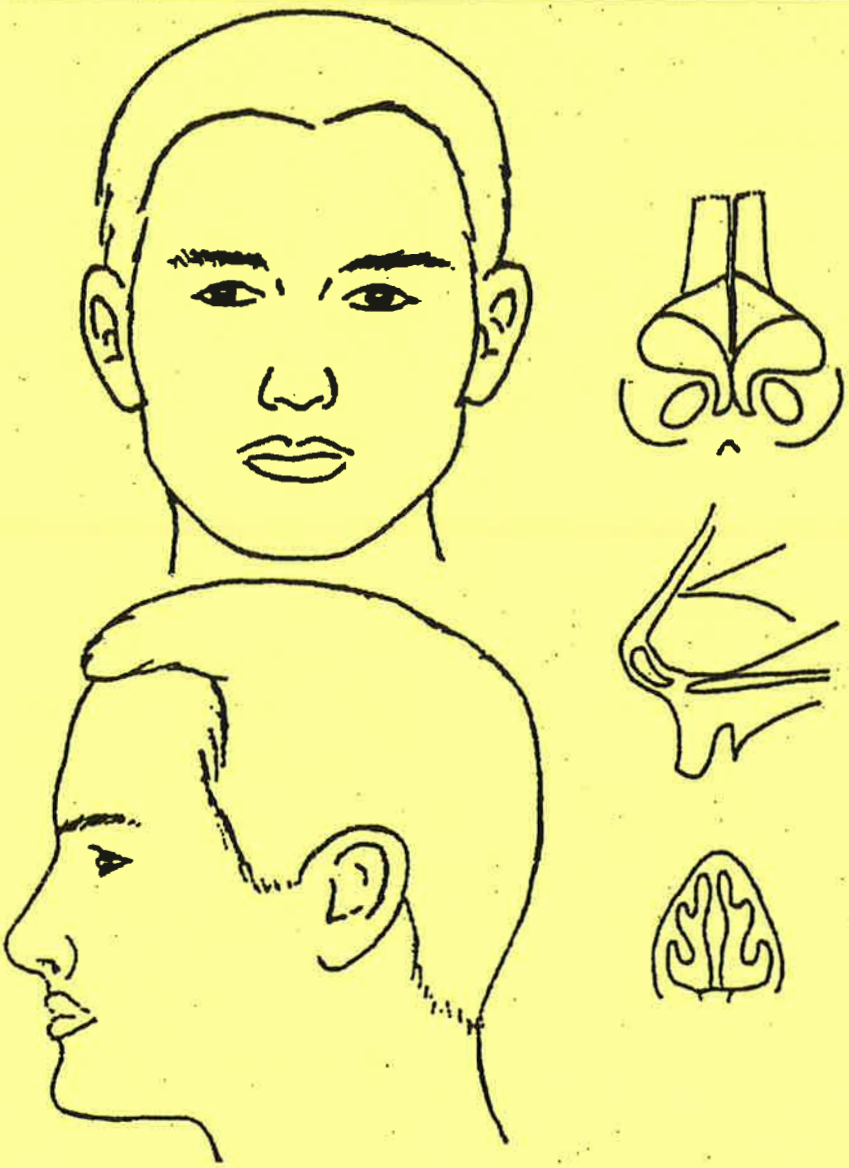
*A Division of E. Gaylon McCollough, MD, LLC
350 Cypress Bend Drive
Gulf Shores, Alabama 36542

## PATIENT WORKSHEET

Today's Date:_____
Name:_____
Address:_____
#Street City State Zip
Date of Birth:_____Age:_____Sex (M) (F)
Height:_____Weight:_____
Phone: Home_____Business_____Cell_____
Email:_____Fax:_____
SS#:_____
Insurance Carrier_____Number_____
Is this a Preferred Care Program(PMD)?_____
Insured's Name_____
Person Responsible for Bill_____
Name(s) of family members who have been treated by our Clinic Staff:

Please write in your own words, what condition(s) you wish the doctor to discuss with you:_____

Please do not write below this line



For Office Use Only
Pre-consultation: Information, Questions, and Instructions
By:_____Comments:_____

CONSULTATION

Date:_____Examination, History & Questionnaire, Book, Photo, Procedures & Recommendations:

# McCOLLOUGH PLASTIC SURGERY CLINIC*

And

# McCOLLOUGH LIFE ENHANCEMENT NETWORK

*CONSULTATION AND MEDICAL HISTORY/DATA*

Name_____Date of Birth_____Today's Date_____

Address: Home_____
Street City State Zip Telephone

Business_____
Street City State Zip Telephone

Email_____Cell Phone (____)_____

Marital Status: S, M, D, Sep., Widowed Spouse's name_____ Age(s) of Children_____

Your Occupation/Employer_____Spouse's Occupation/Employer_____

How were you referred to us? _____Name of family members who are our patients_____

***IN WHICH SURGICAL PROCEDURE(S) AND/OR LIFE ENHANCEMENT SERVICES ARE YOU INTERESTED?***

Rhinoplasty (nose)_____Chin_____Face or Neck Lift_____Eyelids_____Chemical Peel_____Dermabrasion____Scar revision_____

Protruding Ears_____Removal of Cysts, Warts, Moles, Etc._____Breast Surgery_____Body Contour Surgery (tummy tuck)_____

Suction Lipectomy_____Weight Management_____Professional Skin Care_____Injectible Fillers/Botox_____Nutritional Counseling, including

Nutritional Supplementation_____ Hormone Modulation Therapy_____ Teeth Whitening/Cosmetic Dentistry_____ Health Testing____

Other_____

**What specifically, do you wish to have corrected: (i.e. what don't you like about the above condition(s)?** _____

_____

When did you begin to consider surgical correction?_____ Have you discussed this surgery with your family? Yes/No Are they agreeable? Yes/No

Why have you decided to have it done at this point in time?_____

Have you consulted any other doctor about this? Yes/No When: _____

Have you had previous cosmetic, plastic or reconstructive surgery? **Yes/No** When, and what was done?_____

_____

Who performed the surgery?_____Where was it performed?_____

Were you satisfied with the results?_____If not, why?_____

Have you had ***any other surgery***, or an injury, to the face? Nose, neck or eyes?_____

When?_____Describe, as best you can_____

Has anyone in your family or a close friend had cosmetic, plastic or reconstructive surgery?_____

What was done?_____By whom?_____

Have you had any other prior surgery? (What was done & when was it preformed?) In the head & neck area?_____

On your skin?_____On your teeth or gums?_____In your chest?_____In your abdomen?_____

On the reproductive system?_____On your back, arms, or legs?_____Other:_____

Were there complications? **Yes / No** Did you have a normal recovery? **Yes/ No**

Did the results meet your expectations?_____Please explain_____

**MEDICAL HISTORY (circle appropriate response)**

**No/ Yes** Are you now taking any drugs or medications, including hormone replacement therapy, vitamins, nutritional supplements, green tea, herbs, etc?

List them if you can_____

**No/ Yes** Are you allergic to any latex, medication, creams, tape, make-up, etc.?

List them if you can _____

When was your last physical examination?_____

Who is your family doctor?_____Address_____

City_____State_____Telephone_____

**No/ Yes** Would you object to our contacting him/her for additional information pertaining to your health?

(Continued on back)

**MEDICAL HISTORY** (continued)

No Yes Have you ever received local anesthesia ("Novocain, Xylocaine" etc.) by a dentist or doctor? (Circle appropriate response)
No Yes Did you have a "reaction" to any anesthesia? Explain_____
No Yes Are you considered a healthy person?
No Yes Do you take vitamins/nutritional supplements regularly? Explain _____

Do you or any family members have: (indicate who)

Heart trouble_____Excessive bleeding tendencies_____Psychiatric or "nerve" problems_____
High blood pressure_____Diabetes_____Thyroid problems_____
Excessive bruisability_____Excessive scarring_____Delayed or poor healing_____

Do you have any history of bleeding: (indicate which)

From the nose_____In the urine_____Vomiting blood_____
From the rectum_____Coughing up blood_____Other?_____

No Yes Do you have hay fever, nasal allergies or asthma? Explain_____
No Yes Have you (or a member of your family) experienced swelling of the tongue and throat that caused difficulty with breathing?____
Explain _____
No Yes Do you have (or have you had) any problems with your eyes or vision? Explain_____
No Yes Do you have frequent pains in the chest or tire easily from exercise?
No Yes Has a doctor ever said you had "heart trouble"? Explain_____
No Yes Do you have "stomach trouble" or ulcers? Explain_____
No Yes Do you have (or have you had) chest or lung problems? Sleep Apnea? Explain_____
No Yes Have you ever had liver, gall bladder trouble, "yellow jaundice", or hepatitis? Circle which one(s)
No Yes Have you been bothered by kidney or bladder problems? Explain_____
No Yes Do you or any family members suffer from "arthritis" or autoimmune conditions (lupus, scleroderma, etc)?
No Yes Do you ever experience poor circulation in your fingers or toes?
No Yes Do you have frequent skin infections, irritations or rashes? Circle which one(s)
No Yes Have you ever had fever blisters or "cold sores" or canker sores on your face, lips or in your mouth? Circle which one(s)
No Yes Have you been bothered by genital herpes?
No Yes Do you often have severe headaches or dizzy spells? Circle which one(s)
No Yes Has any part of your body ever been paralyzed or numb? Explain_____
No Yes Did you ever have a convulsion or seizure? Explain_____
No Yes Have you ever received treatment for your genital or reproductive area? Explain_____
No Yes Were you ever told you had any venereal disease or AIDS? Explain_____
No Yes Are you frequently sick or ill?
No Yes Do you worry about your health?
No Yes Were you ever treated for anemia or any problems with your blood? Explain_____
No Yes Have you ever taken hormones or thyroid medication? Explain_____
No Yes Do you smoke or use nicotine in any fashion (patches, gum, etc)?
No Yes Do you usually take two or more alcoholic drinks a day?
No Yes Have you ever received treatment for abuse of alcohol or drugs? Explain_____
No Yes Do you often get depressed or blue?
No Yes Do you usually feel unhappy, depressed, or tired?
No Yes Are you considered a nervous person?
No Yes Did you ever have a "nervous breakdown"? Explain_____
No Yes Have you ever received medical treatment for a "nervous breakdown"? Explain_____
No Yes Are you easily upset or irritated?
No Yes Do you tend to hold a "grudge" when someone angers you?
No Yes Have you ever considered consulting a psychiatrist, psychologist or counselor? Explain _____
No Yes Have you ever been under the care of a psychiatrist or psychologist? Explain_____

***If you are a woman,*** are you still having periods? **Yes/No** Are they often irregular? **Yes/No**
***If you are a man,*** have you ever had prostate problems? **Yes/No**

If you have any other health problems that have not been covered, please explain: _____
_____

No Yes Do you accept the fact that every medical and surgical treatment is associated with risks and other imponderables?
No Yes Have you read our patient reference book, **"The Appearance Factor"** including the patients Bill of Rights/Responsibilities?
No Yes Do you agree to comply with the pre and post treatment instructions while you are under our care?

Signed_____Date_____

Thank you for your confidence. The information you have provided is essential in our comprehensive evaluation in your case. Please re-read the book **"The Appearance Factor"** and write down any questions you may have so that we may discuss them in detail prior to treatment and/or surgery. If you do not have the book, please ask for one. You may also download the entire book at www.mccolloughplasticsurgery.com. It is an important part of informing you about your surgery.

# MCCOLLOUGH INSTITUTE FOR APPEARANCE AND HEALTH

REQUEST FOR PATIENT INFORMATION

## PERSONAL INFORMATION

Name _____

Address _____

Social Security _____ Date of Birth _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Email _____

| | | |
|---|---|---|
| May we contact you at your home phone number? | YES | NO |
| May we leave you a voice message at your home phone number? | YES | NO |
| May we contact you at your work phone number? | YES | NO |
| May we leave you a voice message at your work phone number? | YES | NO |
| May we contact you at your cell phone number? | YES | NO |
| May we leave you a voice message at your cell phone number? | YES | NO |
| May we contact you at your email address? | YES | NO |
| May we contact you regarding marketing information and events at your email address? | YES | NO |

Who, if anyone, may we have your authorization to release your medical information if they should contact us?

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Who may we contact in an Emergency _____

Relationship _____ Phone number _____

Your Primary Doctor's Name _____

Address _____

Phone number _____

**********

## TREATMENT INFORMATION

How did you learn of the McCollough Institute for Appearance and Health?

_____

Your appointment today is with Dr. _____

What do you hope to accomplish at the McCollough Institute?

_____

_____

_____

*Continued on back of page*

What factors prompted you to contact the McCollough Institute?

_____

_____

Please share any medical and/or emotional concerns that you are currently experiencing or have experienced in the past.

_____ _____

_____ _____

_____ _____

_____ _____

If you have received help for any of these concerns, please provide the doctor's name.

_____

Are you interested in learning about other services offered by the McCollough Institute for Appearance and Health?

If, yes please check all services you are interested in learning about.

- ❑ Plastic Surgery
- ❑ Hair Transplant
- ❑ Skin Cancer Screening
- ❑ Cosmetic, Restorative, Family and Sedation Dentistry
- ❑ Weight Loss/Weight Management
- ❑ Advanced clinical testing for vitamin, mineral, antioxidant and/or other essential micronutrient deficiencies (Spectracell)
- ❑ Physician nutritional and supplement Counseling
- ❑ Max-A-Life Vitamins and Nutritional Supplements
- ❑ Max-A-Life Advanced Health Systems Meal Replacement Bars
- ❑ Cosmetic hand therapy (brown spots, large veins, wrinkles)
- ❑ IPL – Intense Pulse Light (treats hyperpigmentation (red/brown spots) and hair reduction)
- ❑ $C0^2$ Fractional Skin Resurfacing
- ❑ Facials, Skin Care, Massage, Make-up and other Spa Services
- ❑ Injectables: Botox and Dermal Fillers
- ❑ Family Counseling, Couple Counseling, Personal Counseling and Life Enhancement Coaching

In order to better serve you, with your permission, this information will be shared with doctors and specialists within the McCollough Institute.

It is OK to share the information included on these pages with the other doctors. _____ (Please initial here)

*Each service in the McCollough Institute for Appearance and Health is privately owned and operated and there is no ethical or legal connection between any of the individual businesses.* *9/13*

# McCOLLOUGH PLASTIC SURGERY CLINIC

LEFT EYE

OFFICE USE ONLY
No Glasses _____
Glasses _____

350 Cypress Bend Boulevard
Gulf Shores, Alabama 36542

RIGHT EYE

OFFICE USE ONLY
No Glasses _____
Glasses _____

By _____
Date _____

## EYE EVALUATION SHEET

Your Name _____ Date _____

Your Eye Doctor's Name & Address _____

_____ Date of last examination or visit to his office _____

NO YES 1. At your last examination were you told you have <u>any</u> problems with your eyes?
Explain _____

NO YES 2. Do you require glasses or contacts lenses? (Circle which)

NO YES 3. Have you had any injuries or surgery to the eyes or lids? (By whom?)
Explain _____

NO YES 4. Are you bothered by frequent irritations or "allergies" of the eyes or lids?

NO YES 5. Do you feel your eyes or lids swell excessively?

NO YES 6. Do you now or have you ever taken medications or drops for the eyes?
Explain _____

NO YES 7. Are you bothered by "dry eyes"?

NO YES 8. Do your eyes "water" or tear spontaneously (without emotional stimulation)?

NO YES 9. Do you now or have you ever had any visual problems with one or both eyes?
Explain _____

NO YES 10. Are there any other problems we have not asked about that you feel we should know? Explain _____

## PLEASE READ THE FOLLOWING AND CARRY OUT THE INSTRUCTIONS

1. Cover your <u>RIGHT</u> eye and read THIS sentence with your LEFT eye.

NO YES Are you able to read it comfortably?
_____ with glasses _____ without glasses

2. Cover your LEFT eye and read THIS sentence with your RIGHT eye.

NO YES Are you able to read it comfortably?
_____ with glasses _____ without glasses

If there is any difference in your vision please indicate:
_____ Right eye stronger
_____ Left eye stronger
_____ Both eyes same (approximately)

I signify that to the best of my knowledge the information provided above is accurate.

Signed; (patient) _____ Date _____

# MCCOLLOUGH PLASTIC SURGERY CLINIC

350 Cypress Bend Drive
Gulf Shores, Alabama 36542
Office: 251-967-7600
FAX: 251-967-7647


## ABOUT PAYMENTS AND INSURANCE

Health insurance is considered a method of reimbursing ***patients*** for fees paid to the doctor and should not be considered a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge after a deductible. It is the patient's responsibility to pay all ***fees in advance***. Any insurance reimbursement will be paid directly to the ***patient*** by the insurance company.

### FOR YOUR APPROVAL

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my medical records.

The authorization will remain in effect until revoked by me in writing. A photocopy of this authorization is to be considered as valid as an original. I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize McCollough Plastic Surgery Clinic to release all information necessary to secure payment.

In the unlikely event it becomes necessary to turn my account over to an attorney for collection of any amount due hereunder, I agree to be responsible for all costs of collection including attorneys fees. I also understand that should this be necessary I will waive the rights to exemption under the laws of the State of Alabama.

Signed_____ Date_____

Responsible Party_____ Date_____

# NOTICE OF RECEIPT OF THE MCCOLLOUGH PLASTIC SURGERY CLINIC PRIVACY PRACTICES

I have received, read and understand McCollough Plastic Surgery Clinic's Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the McCollough Plastic Surgery Clinic at any time to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you must restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Print): _____

Relationship to Patient: _____

Signature: _____

Date _____

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## OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

| Date: | Initials: | Reason: |
|---|---|---|
| | | |