Marc Malek, M.D
Aesthetic Plastic and Reconstructive Surgery
8438 E. Shea Blvd. Suite 101 Scottsdale, AZ 85260
480-551-2040, 480-889-0704 (fax)

PATIENT INFORMATION

Last Name:	**First Name:**	
Street Adress:		
City:	**State:**	**Zip:**
How did you hear about us? (circle one) Yellow pages /Patient Referral / Dr. Refferal / Ad / Seminar		
E-mail Address:		
Date of Birth:	**Home Phone:**	**Cell Phone:**
SSN:	**Reason for Visit:**	
Patient's Employer:		**Occupation:**
Employers Phone:		**Can We Contact You At Work: Yes / No**

FAMILY

Spouse/Legal Guardian:	**Relationship to Patient:**
Spouse/Guardian Employer:	**Phone of Employer:**

We accept Cash/Cashier Checks/Money Orders/Visa/AMEX Mastercard. Finance options are also available.

INSURED PATIENTS: Please provide our office with a signed and completed form. In selective situations, we may file your claim to your insurance company. Your policy is a contract between you and your insurance company and any services not covered or inadequately covered by your policy will be your responsibility. Please note that this office is not bound by the usual and customary fees provided by insurance companies.

INSURED'S OR AUTHORIZED PERSONS SIGNATURE: I authorize the release of any medical or other information necessary to process this claim.

PHOTO CONSENT: I authorize Dr. Marc Malek M.D to take photos of me prior to and after any procedure. I understand that these photos are the property of the office and will not be used for any publication without special written consent by me.

Signature: _____ Date: _____

Personal History Sheet

Date: _____ Name: _____ Referred By: _____

Age: _____ Birth Date: _____ Height: _____ Weight: _____ Smoker: Yes/No

In Case of Emergency Notify: _____ Phone Number: _____

Past Medical History: Have you had anything other than the usual childhood diseases:

(If yes, explain): _____

_____

Current Medications: _____

Drug Allergies: _____

Previous Surgeries & Approximate Year (Include prior cosmetic surgeries): _____

_____

_____

Please answer the following questions, (do not answer if unsure). In the past 6 months, have you had…?

H&N	Any eye disease, faulty sight or eye pain	No	Yes
	Any ear disease, impared hearing	No	Yes
	Any trouble with nose, sinus;, mouth or throat	No	Yes
	Hard lumps on tongue, lips or mouth	No	Yes
	Glaucoma	No	Yes
CVR	Chronic/frequent cough	No	Yes
	Chest pain or angina pectoris	No	Yes
	Spitting up of blood	No	Yes
	Night sweats , chills or fever	No	Yes
	Shortness of breath	No	Yes
	Wake up short of breath	No	Yes
	Palpitation or fluttering of heart	No	Yes
	Swelling of hands, feet, or ankles	No	Yes
	Rheumatic fever	No	Yes
	Tuberculosis	No	Yes
	High or low blood pressure	No	Yes
	Heart murmur	No	Yes
	Heart attack	No	Yes

GI	Stomach Pain, ulcer or pain	No	Yes
	Indigestion, vomiting or nausea	No	Yes
	Liver or gallbladder disease	No	Yes
	Recent change in bowl action or stool	No	Yes
	Constipation or diarrhea	No	Yes
	Cirrhosis of liver	No	Yes
	Jaundice (yellow)	No	Yes
GU	Kidney disease or stone	No	Yes
	Bladder disease	No	Yes
	Albumin, sugar, pus or blood in urine	No	Yes
	Difficulty controlling urine	No	Yes
ENDO	Abnormal thirst	No	Yes
	Diabetes	No	Yes
	Thryroid disease	No	Yes
	Any diabetes in family	No	Yes
	List _____		
HEMO	Anemia	No	Yes
	Do you bleed or bruise easily	No	Yes
	Any unusual bleeding after surgery or dental work		
	Any family member a free bleeder	No	Yes
	If yes, please specify_____		
NEURO	Fainting spells	No	Yes
	Loss of consciosness	No	Yes
	Convulsions/epilepsy	No	Yes
	Paralysis Attacks	No	Yes
	Dizziness	No	Yes
	Often sever headaches	No	Yes
	Migraine headaches	No	Yes
	Nervous breakdown	No	Yes
Pregnancy	Total Number_____		
	Total Number of children_____		
	Are you, or might you be pregnant now	No	Yes
	Any female problems now	No	Yes
	Is there a history of breast cancer in your family	No	Yes
Tobacco	Cigarettes_____ packs per day		
	Cigars_____ Pipe_____		

This is a confidential report of your medical history and will be kept in this office. Information contained herin will not be released to any persons or organizations except when you have authorized us to do so.