Kenrick A. Spence M.D. P.A.

Hillcrest Plastic Surgery

PATIENT INFORMATION

(Download and return in E-mail info@spencemd.com)

Date of Appointment: 3/30/2021

Patient's Name: Click or tap here to enter text. Click or tap here to enter text. Click or tap here to enter text.
First / MI / Last

Reason(s) for today's visit: Fillers

Age: 67 **Date of Birth:** August 17, 1953 **Marital Status: M☐S☐W☒ D☐Sep☐**

Residence Address: 1056 Wood Dale Cir **City:** Oviedo **State:** FL

Zip Code: 32765

Mailing or Alternate Address: Click or tap here to enter text. **City:** Click or tap here to enter text. **State:** same as bove **Zip Code:** Click or tap here to enter text.

Home Phone: 321-262-9441 **Business Phone:** Click or tap here to enter text.

Cell Phone: same **Email Address:** drlindagalloway@gmail.com

Height: 5'3 **Weight:** 149 lb

Sex: Male☐ Female☒ Race: Black

Social Security Number: Click or tap here to enter text. **Driver's License Number:** Click or tap here to enter text.

May we contact you at work? Yes☒ No☐ Occupation: Ob-Gyn Physician **Employer:** self-employed **Business Address:** Click or tap here to enter text.

Husband or (Father if child is a minor): Click or tap here to enter text. Click or tap here to enter text.
Name / Date of Birth
Click or tap here to enter text. Click or tap here to enter text.
Phone Number / Social Security Number

Wife or (Mother if child is a minor): Click or tap here to enter text. Click or tap here to enter text.
Name / Date of Birth
Click or tap here to enter text. Click or tap here to enter text.
Phone Number / Social Security Number

Emergency Contact: Click or tap here to enter text. Dr. Anna Lizama 407-435-2339
Name / Relationship / Phone Number

Primary Care Physician: Dr. D. Greaves **Phone:** 407-843-1180

Have you or any members of your family been treated here before? Yes☐ No☒ Name: Click or tap here to enter text.

I heard about Hillcrest Dermatology and Plastic Surgery through:

Yellow Pages☐ Friend☐Physician☒TV☐Radio☐Publication☐Website☐Other☐ Please Name Publication: Click or tap here to enter text. **Other:** Click or tap here to enter text.

If referred by a friend or physician, please list their name so we may thank them: Click or tap here to enter text.

All professional services rendered are charged to the patient.

Pre-Operative History and Physical

Patient Name: Linda Burke **Date of Birth:** 8/17/1953

Height: Click or tap here to enter text. **Weight:** Click or tap here to enter text.

Allergies: (please include food, latex, adhesives, tape, oral or topical medications)

NKA

List previous surgeries and/or hospitalizations and dates: (including cosmetic services)

myomectomy, B/L breast implant, OD cataract extraction

List all medications you are taking: (please, include non-prescription drugs, vitamins and minerals)

Artorvastatin, Losartan, HCTZ, OTC: CoQ10, Lutein, Bilberry, Zeoxanthin

Social History: Alcohol (type and amount): Click or tap here to enter text.

Smoking (type and amount): none

Family History: Has any blood relative ever had the following

Breast Cancer ☐ If so, relationship Click or tap here to enter text.

Testicular Cancer ☐ If so, relationship Click or tap here to enter text.

Problems with Anesthesia ☐ Bleeding or clotting disorder ☐

Medical History: Do you currently or have you ever had the following (please check all that apply)

☐ Heart Disease
☐Mitral Valve Prolaps
☐Hepatitis/Liver Disease
☐Glaucoma
☐Lupus
☒Anemia
☐Tuberculosis
☐Diabetes
☒Weight Changes
If so, lose or gain and amount
Lost 10 lbs b/c changed my diet lbs
☐Swollen Feet/Ankles
☒Skin Rash
☐Chronic Cough
☐Dry Eyes
☐Psoriasis

☐Anxiety
☐Sleep Apnea
☐Chest Pain
☐High Blood Pressure
☐Stomach Ulcer/Acid Reflux
☐Kidney Disease
☐Auto Immune Deficiency
☐Bleeding Tendency
☐Stroke
☐Malignant Hyperthermia
☐Seizures
☐Joint or Muscle Pain
☐Chronic Diarrhea
☐Wear Contact Lenses
☐Pain/Blood/Frequency with Urination
☐Eczema

☐Irregular Heart Rate
☐Cancer
☐Arthritis
☐Asthma
☐Thyroid Disease
☐Blood Clot
☐AIDS or HIV
☐Latex Allergies
☐Fainting
☐Jaundice
☐Swollen Lymph Nodes
☐Depression
☐Previous use of Accutane
☐Squamous Cell Carcinoma
☐Basal Cell Carcinoma
☐Actinic Keratosis
☐(Skin Pre-cancers)
☐Dysplastic/Atypical moles

PLEASE EXPLAIN ALL CHECK MARKS:

Skin rash from Chronic insufficiency, h/o HTN, Alpha-thalasemia minor anemia

I verify that the above information is true and accurate to the best of my knowledge.

Patient Signature: _____ **Date:** Click or tap here to enter text.

Purpose for today's visit Click or tap here to enter text.

*Please identify the areas you wish to discuss in the **future** with us*

Areas for Enhancement

Name: Click or tap here to enter text. **Date:** Click or tap here to enter text.

Please mark the areas of **future** interest and the level of priority, using the following: 1-Low 2-Medium 3-High

Body Contouring

Arms Thighs Breasts Abdomen Buttocks

Other Click or tap here to enter text.

Skin Care

Acne Small Broken Capillaries Un-Even Skin Tone Skin Texture

Stretch Marks Longer Eye Lashes Dry Skin Oily Skin

Sun Damaged Face Sun Damaged Hands Moles Freckles

Skin Products Dark/Age Spots Large Pores Sun Damaged Chest

Other Click or tap here to enter text.

Facial Rejuvenation

1 Wrinkles or Lines 2 Sagging or Drooping Skin Ears Face

Eye Lids Brows Skin Texture Neck Lips

Other Click or tap here to enter text.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PRINTED NAME: Click or tap here to enter text.

In connection with the medical services that I am receiving from Hillcrest Dermatology and Plastic Surgery, I hereby authorize disclosure of any and/or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

A. Any third-party payor covering the medical services of the patient;
B. Other health care professionals and institutions involved in the delivery of health care to the patient;
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services:
E. Pharmacies; and
F. As otherwise required by law.

I further consent that photographs may be taken of me, or parts of my body, under the following conditions:

1. The photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him.
2. The photographs shall be taken by my physician or by a photographer approved by my physician.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. This consent is valid from the date executed until revoked in writing by the patient. Please understand that revocation of the consent will not affect any action we took in reliance on consent before we received your revocation and we may decline to treat or continue treating you if you revoke this consent.

I further understand that I have been given special access to the physician's privacy notice and that I have the opportunity to place special restrictions upon the consent (see below). I may request a copy of the privacy notice at any time by contacting:

Contact person: **Rayer Headley**
Address: **130 Hillcrest Street, Orlando FL 32801**
Telephone: **407-999-2585**

Special restrictions:

YOU MAY CONTACT ME AT: ☒HOME ☒WORK ☐CELL

YOU MAY LEAVE A MESSAGE AT: ☒HOME ☒WORK ☒CELL

CONTACT PHONE AND ADDRESS: Click or tap here to enter text. Click or tap here to enter text.
NAME: Click or tap here to enter text. **RELATIONSHIP:** Click or tap here to enter text.
CONTACT PHONE AND ADDRESS: Click or tap here to enter text. Click or tap here to enter text.

ADDITIONALLY, YOU HAVE MY PERMISSION TO DISCLOSE ANY OR ALL INFORMATION
TO: Click or tap here to enter text.
NAME: Noone **RELATIONSHIP:** Click or tap here to enter text.
CONTACT PHONE AND ADDRESS: Click or tap here to enter text. Click or tap here to enter text.
NAME: Click or tap here to enter text. **RELATIONSHIP:** Click or tap here to enter text.

Signed: _____
Date: _____
Personal Representative (if applicable):_____
Witness: _____

For office use only:

☐Signed form received

☐Patient Refused

☐Emergency

☐Language barrier prevented acknowledgement or signature

Staff member's name: _____ Date: _____

Confidential Skin Health Questionnaire

The following information is necessary in determining how your skin will react during initial skin treatments or post-operative surgery. Please complete each of the following questions as your answers will determine the proper protocol to be used in the management of your skin care. If the question does not apply to you, please write "N/A" (not applicable).

Name: Click or tap here to enter text. **Sex:** ☐**Male** ☒**Female**

Email Address: Click or tap here to enter text. **Date:** 3/29/2021

Yes	*No*	
☒	☐	**How often do you exercise?** 2-3 x/wk
☐	☒	**Are you under stress at this time?** Click or tap here to enter text.
☐	☒	**Have you ever had an allergic reaction to a food, drug, or skin care product? Please explain.** Click or tap here to enter text.
☐	☒	**Have you or anyone in your family had Melanoma?** Click or tap here to enter text.
☒	☐	**Have you ever been to a dermatologist or plastic surgeon? If yes, for what procedure or treatment?** Click or tap here to enter text.
☐	☒	**Do you tan in a ☐tanning bed or ☐the sun? (Check all that apply)**
☐	☒	**Does your skin itch from certain products? (Cosmetics, aspirin, fabrics, etc.) Explain:** Click or tap here to enter text.
☐	☒	**Do you have ☐hypo-thyroidism or ☐hyper-thyroidism? (Choose one)**
☐	☒	**Do you have any metal implants in your body (except fillings) such as a pacemaker, pins in bones, or a copper IUD? If yes, explain.** Click or tap here to enter text.
☐	☒	**Have you ever had a herpes simplex infection in the area being treated?**
☐	☒	**Do you have an active herpes simplex infection in the area to be treated?**
☒	☐	**Have you ever had any other skin disease?** Discoloration from Chronic Venous Insuficiency on B/L LE
☐	☒	**Have you ever used Accutane? If yes, last date?** Click or tap here to enter text.
☒	☐	**Have you ever suffered from acne?**
☐	☒	**Do you form thick or raised scars from cuts or burns?**

FEMALES ONLY:

Yes	**No**	
☐	☒	**Do you have regular periods?**
☒	☐	**Post menopause?**
☐	☒	**Are you pregnant?**
☐	☐	**Do you have dark areas on your face that occurred during pregnancy?**

MALE AND FEMALE

On a daily basis how much of the following liquids do you drink?

Coffee Click or tap here to enter text. **Tea** Click or tap here to enter text. **Water** 4-6 glasses H2O **Soda** Click or tap here to enter text. **Juice** Click or tap here to enter text. **Other** Click or tap here to enter text.

List any medications you apply topically:

Trentinoin 0.1%

Please specify "C"(current) or "P"(past) for any products you are currently using or have used in the past:

Hydroquinone	Eldoquin Forte	Melanex	Retin A/Tretinoine
Cleocin	Erythromycin	EmGel	Metro Gel
Benzoyl Peroxide	Hytone	Lidex	Zovirax
Tetracycline	Accutane	Alpha-Hydroxy Acids P	Renova
Finacea	Aldara	5-FU/Efudex	PDT

Other: Click or tap here to enter text.

What does your diet consist of? Fish, veg, no meat

How does your skin react to sun? Without sunblock, when exposed to one hour of direct sun, do you (Choose one)

☐Always Burn ☐Burn First, then Tan ☒Tan ☐Always Tan/Never Burn

Please check off any of the following that apply to your skin:

Blackheads☐	Whiteheads☐	Enlarged Pores☒
Flakiness☐	Acne Scars☐	Deep Wrinkles☒
Fine Lines☒	Dark Spots☐	Dryness☐
Shiny Skin☐	Redness☐	Painful Pimples☒

Have you ever had any of the following?

Glycolic Peels☐	Dermabrasion☐	Facials☐
TCA Peel☐	Obagi Blue Peel☐	Laser Resurfacing☐
Microdermabrasion☐	Jessner's Solution Peel☐	Enzyme Peel☐
Other: Click or tap here to enter text.	MicroNeedling ☐	Intense Pulsed Light☐

How many times a day do you wash your face?twice

What brand name skin care products are you using:

Cleanser: Click or tap here to enter text.

Toner: Click or tap here to enter text.

Moisturizer: Click or tap here to enter text.

Serums: Click or tap here to enter text.

Sunscreen (include SPF#): Click or tap here to enter text.

Eye Cream: Click or tap here to enter text.

Any other products? Click or tap here to enter text.

What specific concerns do you have about your skin and what changes would you like to see?

Deep naso-labial folds

Signature: linda burke galloway Date: 3/29/2021