Cosmetic Plastic Surgery
of Maryland

Arundel Mills Surgery Center, Inc.

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Today's Date:

PATIENT INFORMATION

Last name:	First Name:	Middle:

Marital Status: (Check one) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Date of Birth:	Age:	Sex: ☐ Male ☐ Female

Address:	Height:	Weight:

City:	State:	Zip:

Social Security Number:	Home Phone:	Cell Phone:

E-mail Address:

Occupation:	Employer:	Employer Address:	Employer Phone:

How did you hear about us?

If anyone, what is the first and last name of the person that referred you?

MEDICAL INFORMATION

Reason for visit:

Pharmacy:	Address:	Pharmacy Phone:

Physician Requesting Consultation:	Requesting Physician's Address:	Requesting Physician's Phone:

Primary Care Physician (PCP):	Send Report: ☐ Yes ☐ No

PCP's Address:	PCP's Phone:	PCP's Fax:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Contact Number:

HEALTH HISTORY

Do you smoke or chew tobacco?	Do you drink alcohol?	Do you exercise?
☐ Yes ☐ No How much? ___________	☐ Yes ☐ No How much? _________	☐ Yes ☐ No

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HEALTH HISTORY (CONTINUED)

Please list all medicine you are currently taking: Prescription and over-the-counter medications (examples: aspirin, antacids) and dietary supplements (example: vitamins) and herbals (examples: ginseng, gingko). Include any medications taken as needed (example: inhaler, EpiPen).

Medication Name	Dose (How much?)	Frequency (How often?)

Please list all allergies:

____

____

____

____

____

____

Are you allergic to Latex?

☐ Yes

☐ No

Are you currently taking oral contraceptives?

☐ Yes

☐ No

Are you currently experiencing any of the following symptoms?

☐ None
☐ Bleeding
☐ Blind Spells
☐ Breast Pain
☐ Chest Pain
☐ Chronic Cough
☐ Diarrhea
☐ Dizziness
☐ Dry Eyes
☐ Fainting Spells
☐ Fever
☐ Jaundice
☐ Rectal Bleeding
☐ Ringing in the Ears
☐ Severe Headaches
☐ Severe Indigestion
☐ Shortness of Breath
☐ Spitting up Blood

Please check if you have or ever had any of the following:

☐ Anemia
☐ Angina
☐ Anxiety Disorder
☐ Arthritis
☐ Asthma
☐ Back Pain
☐ Bladder Trouble
☐ Blood Disease
☐ Bronchitis
☐ Cancer/Tumor
☐ Chronic Cough
☐ Cirrhosis
☐ Colon Disease
☐ COPD
☐ Coronary Artery Disease
☐ Dentures
☐ Depression
☐ Diabetes
☐ Emotional Disorder
☐ Emphysema
☐ Epilepsy/Seizures
☐ Fainting/Dizziness
☐ GI Disorder
☐ Hay Fever
☐ Hearing Aid
☐ Heart Attack
☐ Heart Disease
☐ Heart Failure
☐ Hepatitis
☐ Hiatal Hernia
☐ HIV
☐ Hypertension
☐ Implants/Artificial
☐ Irregular Heartbeat
☐ Jaundice
☐ Kidney Disease
☐ Kidney Stones
☐ Liver Disease
☐ Loose Teeth
☐ Lung Disease
☐ Lyme Disease
☐ Neurological Disorder
☐ Osteoporosis
☐ Painful Joints
☐ Pacemaker
☐ Paralysis
☐ Pneumonia
☐ Prolonged Bleeding
☐ Recent Cold
☐ Shortness of Breath
☐ Sickle Cell Anemia
☐ Sleep Apnea
☐ Stroke
☐ Swollen Ankle
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcer
☐ Other:

Family History – List any medical conditions of immediate family:

Have you ever had any serious illnesses, operations or hospitalizations? ☐ Yes ☐ No

If yes, please describe and list dates:

The above information is true to the best of my knowledge. If applicable, I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance, co-pay and/or deductible. I also authorize Salman Ashruf, MD, FACS, or the insurance company to release any information required to process my claims.

Patient/Guardian Signature: ______________________________ Date: ____________________

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MY CONSULTATION GOALS

Name:________________________________ Date:________________________

Date of Birth:____________________

How did you hear about us?

A) Please list the top 3 problems on your "Hit List" that you would like to see improved after surgery (you may list fewer)

FACE	BODY
1) ____________________	1) ____________________
2) ____________________	2) ____________________
3) ____________________	3) ____________________

B) Please list the next 3 concerns (if applicable) you would want to address during your consultation:

1) ____________________

2) ____________________

3) ____________________

C) What adjective(s) best describe your face or body now?

For example: **FACE:** *rested, youthful, fresh* **OR** *tired, angry, sad, droopy, wrinkly, etc.*

BODY: *tight, firm, balanced* **OR** *droopy, saggy, loose, disproportionate, etc.*

FACE: ____________________

BODY: ____________________

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MY CONSULTATION GOALS (CONTINUED)

Approximate Measurements in Inches:

☐ **Waist:** ________________________ **Hips:** ________________________

D) GOALS: What is it you need to see when you look in the mirror in order to be happy after surgery?

E) If you have surgery, how much downtime and/or time off work can you devote to your recovery?

____ **week(s)**

F) What non-surgical skin concerns bother you? (If applicable)

- ☐ Wrinkles
- ☐ Pores
- ☐ Texture
- ☐ Brown Pigmentation
- ☐ Dark Circles
- ☐ Cellulite
- ☐ Red Vessels
- ☐ Other: ________________________

G) What non-surgical treatments have you had? Check all that apply.

- ☐ Botox
- ☐ Filler
- ☐ IPL/Laser Fotofacial
- ☐ Laser Hair Removal
- ☐ Cellulite Treatments
- ☐ Thermage/ Laser Tightening
- ☐ Fraxel/ Laser Resurfacing
- ☐ Other: ____

H) What is your treatment budget?

- ☐ Up to $500
- ☐ $500 - $1500
- ☐ $1500 - $2500
- ☐ $2500 - $5000
- ☐ $5000 - $7500
- ☐ $7500 and Up

____ ____

Patient's Name Date

____

Patient's Signature

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Salman Ashruf, MD, FACS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS

I, ______________________________________, have been made aware of a Notice of Privacy Practices for Salman Ashruf, M.D., FACS. If you have any questions, please contact the Privacy Officer whose name and contact information is listed below.

____
Please Print Name of Patient or Personal Representative

____
Patient or Personal Representative Signature

____
Date

____
Personal Representative's Relationship or Authority (If applicable)

Privacy Officer:

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify):____