Ritu Chopra, M.D.

465 N. Roxbury Drive, Suite 1001, Beverly Hills, CA 90210
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Date: ______________________________

Name: ______________________________ Age: __________ DOB: ____/____/____

Address: ______________________________ Home Tel: (______)______________________________

City ______________________________Zip________ Wk Tel: (______)______________________________

Email: ______________________________ Cell: (______)______________________________

Referring Physician: ______________________________ SS# ______________________________

How did you hear about Dr. Chopra?____

Have you been to our website?____________ Was our website helpful? ☐No ☐Yes If No, pls. list reason:

____

What is the reason for your visit today? (Circle all applicable procedures below)

Nose & Face	Breast & Body	MediSpa
Primary Rhinoplasty	Breast Augmentation	Botox®
Revision Rhinoplasty	Breast Augmentation with Breast Lift	Restylane®
Brow Lift	Breast Reduction	Perlane®
Facelift	Capsulectomy	Juvéderm®
Neck Lift	Mommy Makeover	Radiesse®
Eyelid Surgery	Abdominoplasty	Enzyme Peel
Facial Implants	Post-Bariatric Body Lift	Laser Hair Removal
Chin Augmentation	Brachioplasty (Arm Tuck)	Skin Tightening Laser
Lip Augmentation	Liposuction	Photo Facial
Lip Suspension	Other________________	Pixel Treatment
Other________________	Other________________	Cellulite Treatment
Other________________	Other________________	Vein Treatment
Other________________	Other________________	Other________________

Please describe why you are interested in having the procedure(s) listed above:______________________

____

____

Have you consulted with other physicians about procedure(s) indicated above: ☐No ☐Yes

If Yes, please describe your understanding of the procedure(s)______________________________

Is this procedure a revision from a previous surgery ☐No ☐Yes If yes, how many previous

surgeries?________________

What is your "ideal time frame" for procedure(s) completion ______________________________

Age ________ Weight ________ Height ____________ B/P ____________ (taken in office)

Employer ______________________ Address ____

Occupation: ____ Marital Status: ________________________________

Primary Insurance Co. ___________________________________ Policy # _____________________________________

Group # ______________ Name of person insured _________________________________ SS# ___________________

Eligibility Phone # ____ Copay _____________________________________

Secondary Insurance Co. ___________________________________ Policy # _____________________________________

Group # ______________ Name of person insured _________________________________ SS# ___________________

Eligibility Phone # ____ Copay _____________________________________

HEALTH INFORMATON

Personal Past History:
Do you have any chronic medical problems? (Circle all that apply)

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Psychiatric Diagnosis	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attack	Liver Disease	Emphysema
Chest Pain	Gastric Reflux	Stomach Problems
	Asthma	Other __________________

Is there a personal or family history of anesthetic complications? ☐ No ☐ Yes

If yes, please explain____

Family History:
Do you have a family history of any medical problems? (Circle all that apply) Please indicate family member.

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Psychiatric Diagnosis	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attack	Liver Disease	Emphysema
Chest Pain	Gastric Reflux	Stomach Problems
	Asthma	Other __________________

Please list all prior operations:	Date	List any complications
1.______________________________________	___________________	______________________________
2. ______________________________________	___________________	______________________________
3. ______________________________________	___________________	______________________________
4. ______________________________________	___________________	______________________________
5. ______________________________________	___________________	______________________________

6. ____________________ ____________ ________________

Please list all prior Hospitalizations: | Date | List any complications

1. ____________________ ____________ ________________

2. ____________________ ____________ ________________

3. ____________________ ____________ ________________

4. ____________________ ____________ ________________

5. ____________________ ____________ ________________

Please list **ALL** medications and/or dietary supplements including:
(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)

1. ____________________ 6. ____________________

2. ____________________ 7. ____________________

3. ____________________ 8. ____________________

4. ____________________ 9. ____________________

5. ____________________ 10. ____________________

Please list **ALL** allergies and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc).

1. ____________________ 4. ____________________

2. ____________________ 5. ____________________

3. ____________________ 6. ____________________

Social History:

Have you ever used tobacco products? ☐No ☐Yes If yes, how long?__________ how much?__________
Which tobacco product(s) have you used?____________________
If you are a former smoker, state the year you stopped: __________________

Past or current use of Nicotine Gum, Patch, or any other type of stop-smoking aid: ☐No ☐Yes
If yes, please list: ____

Alcohol Consumption: _________Never (Do not consume alcohol) ________ Rare (1-2 drinks a week)

_________ Moderate (7-10 drinks a week) _______ Heavy (daily or more than 10 drinks a wk)

Did you ever drink heavily in the past? ☐No ☐Yes

Are you feeling hopeless about the present/future? ☐No ☐Yes

Do you currently have thoughts of harming yourself? ☐No ☐Yes

Review of Systems:

Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR

High Blood Pressure	Y ___	N ____
Heart Attack	Y ___	N ____
Angina/chest pain	Y ___	N ____
Heart bypass surgery	Y ___	N ____
Pacemaker	Y ___	N ____
Heart Failure	Y ___	N ____
Irregular Heartbeat	Y ___	N ____
Heart Murmur	Y ___	N ____
Do you exercise?	Y ___	N ____

Comments: ________________________

NEUROLOGICAL

Stroke	Y ___	N ____
Seizures	Y ___	N ____
Fainting	Y ___	N ____
Dizziness	Y ___	N ____
Headache	Y ___	N ____
Double Vision	Y ___	N ____

PSYCHIATIC

Depression	Y ___	N ____
Anxiety	Y ___	N ____
Psychiatric Care	Y ___	N ____
Obsessive Compulsive Disorder	Y ___	N ____

ENDOCRINE

Diabetes	Y ___	N ____
Thyroid Disease	Y ___	N ____
Taken Steroids	Y ___	N ____

HEMATOLOGIC/ONCOLOGIC/

Bleeding Tendency	Y ___	N ____
Easy Bruising	Y ___	N ____
Anemia	Y ___	N ____
Sickle Cell Disease	Y ___	N ____
Blood clots in legs	Y ___	N ____
Blood clots in lungs	Y ___	N ____
Radiation Therapy	Y ___	N ____

URINARY/REPRODUCTIVE

Kidney Disease	Y ___	N ____
Urinary Disease	Y ___	N ____
Dialysis	Y ___	N ____
If female, could you be preg?	Y ___	N ____

Number of live births______________________

Number of pregnancies ___________________

Date of last mammogram __________________

Date of date of menses (period)______________

RESPIRATORY

Abnormal Chest X-ray	Y ___	N ____
Asthma	Y ___	N ____
Bronchitis	Y ___	N ____
Emphysema	Y ___	N ____
Recent Chest Infection	Y ___	N ____
Shortness of Breath	Y ___	N ____
Shortness of Breath at night	Y ___	N ____
Shortness of Breath on exertion	Y ___	N ____
Cough	Y ___	N ____
Cough with Sputum	Y ___	N ____
Sleep Apnea	Y ___	N ____
-Use a C-PAP Machine	Y ___	N ____

MUSCULOSKELETAL

Sciatica	Y ___	N ____
Herniated disc	Y ___	N ____
Arthritis	Y ___	N ____
Rheumatoid	Y ___	N ____
Neck, Back, Arm,Leg Prob	Y ___	N ____

INFECTIOUS

GASTROINTESTINAL

Jaundice	Y ___	N ____
Hepatitis	Y ___	N ____
Ulcers	Y ___	N ____
Hiatal Hernia	Y ___	N ____
Heartburn	Y ___	N ____

SKIN

Basal cell skin cancer	Y ___	N ____
Melanoma	Y ___	N ____
Staph Infection	Y ___	N ____

EYES

Cataracts	Y ___	N ____
Glaucoma	Y ___	N ____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ______________________________________ and assign directly to Ritu Chopra, M.D., Professional Corporation, all Medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. If the nature of the disability be such that it is not covered by insurance, I will be responsible to the doctor for payment of the entire bill. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

____ ______________________

Signature of Insured/Guardian Date

____ ______________________

Patient‘s Signature	Date