

Andrew P. Ordon, M.D., F.A.C.S.

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

Tel: (310) 248-6250 ♦ Fax: (310) 861-1529

www.DrOrdon.com

Date: _____

Name: _____ Age: _____ DOB: ____/____/____

Address: _____ Home Tel: (____) _____

City _____ Zip _____ Wk Tel: (____) _____

Email: _____ Cell: (____) _____

Referring Physician: _____ SS# _____

How did you hear about Dr. Ordon? _____

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 _____ |

<u>Please list all prior operations:</u>	<u>Date</u>	<u>List any complications</u>
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 ___

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 ___

PSYCHIATRIC

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

MUSCULOSKELETAL

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

ENDOCRINE

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

INFECTIOUS

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

SKIN

Basal cell skin cancer Y ___ N ___
Melanoma Y ___ N ___
Staph Infection 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) _____

EYES

Cataracts Y ___ N ___
Glaucoma Y ___ N ___

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Andrew P. Ordon, 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