Michael A. Epstein, MD, FACS

E-MAIL ADDRESS: ____
By providing us with your e-mail address we will keep you updated with promotions and special events in the office of Michael A. Epstein, MD, FACS, Transcend MedSpa and NorthShore Hair Restoration.

Today's Date_______________

Name: Mr. Miss Ms. Mrs. Dr.____
LAST FIRST MIDDLE

How would you like to be addressed by our office staff?____

PHONE NUMBERS: **PLEASE CHECK WHICH PHONE NUMBER IS BEST TO REACH YOU.**

☐ Home_______________________ ☐ Work _______________________ ☐ Cell _______________________

Address:____
STREET APT# CITY STATE ZIP

Date of Birth___________________ Age_________ Sex: Male ________ Female ________

Employer____________________________________ Occupation ____________________________________

Marital Status: Single ____ Married ____ Divorced ____ Widowed ____ Spouse's Name __________________

Emergency Contact _____________________________Relationship____________________ Phone ____________________

Have you visited our website? (www.maeplasticsurgery.com) Yes _____ No _____

How did you hear about our practice? Please check any and all that apply.
☐ ***Friend/Patient*** – If this person is a patient please let us knows his/her name ___________________________
☐ ***Physician*** – Please let us know his/her name ____
☐ ***Advertisement or News Story***: ☐ New Beauty Magazine ☐ Suburban Woman ☐ Chicago Magazine
☐ ***Yellow Pages***
☐ ***Websites*** – please check the website(s) where you found information about our practice:
☐ maeplasticsurgery.com ☐ loveyourlook.com ☐ Newbeauty.com ☐ lookingyourbest.com
☐ implantinfo.com ☐ liposite.com ☐ faceforum.com ☐ aboardcertifiedplasticsurgeonresource.com
☐ mytummytuckusa.com ☐ myplasticsurgeonusa.com ☐ chicagolipodrs.com ☐ chicagobreastdrs.com

Other Website(s): ____
☐ ***Other*** – Please let us know how you heard about us ____

What is your current weight? __________ Ideal weight? ___________ Height? ____________ **Age: __________**

Please list any medications you have recently taken or are currently taking (including aspirin or ibuprofen products and vitamins/supplements)

____

____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS?

□ YES □ NO

If so, please list: ____

MEDICAL HISTORY (Please check all that apply)

Have you ever smoked or do you currently smoke? Yes_____No_____? If yes, how much?___________________________

Heart disease ______ Sleep apnea ______ Gastric Lap Banding ______ Gastric Bypass ______ Heart murmur ______

High blood pressure ______ Diabetes______ Immune disorders ______ Arthritis________ Back problems ______ Kidney stones ______

Seizure disorders ______

Pregnancies___________Normal Deliveries___________C-Sections____________Miscarriages/Abortions__________________

Did you breast feed? □ Yes □ No

Do you have history of breast cancer? □ Yes □ No Maternal side □ Yes □ No Paternal side □ Yes □ No

Have you ever had a mammogram? □ Yes □ No Date: ______________________

Please list any other medical problems here:

____

____

Do you have any problems with bruising______or bleeding______? If yes, please explain______________________________

Have you ever had a problem with your nerves______ or muscles ______? If yes, please explain_______________________
(Temporary paralysis, nerve injuries, strokes, etc).

Have you ever been treated for any psychiatric illness_____? If yes, please explain___________________________________

Do you wear dentures______ or a retainer_______of any kind?

Do you get fever blisters______or other cold sores______on your lips? If yes, how often_______________________________

Do you exercise regularly? Yes______No______ If so, how often?____

List all diseases that run in your family: ____

SURGICAL HISTORY

Please list all NON-COSMETIC surgeries and approx dates, other injuries and/or hospitalizations, reasons for treatment, etc.

1) ____ 4) ____

2) ____ 5) ____

3) ____ 6) ____

COSMETIC HISTORY

Please list all COSMETIC surgeries and the SURGEONS who performed them (including injections, i.e. Botox, Collagen)
NAME OF PROCEDURE, NAME OF SURGEON, DATE

1) ____ 3) ____

2) ____ 4) ____

PATIENT SIGNATURE____DATE__________________

Michael A. Epstein, MD, FACS

Board Certified Plastic Surgeon

ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Michael A. Epstein, MD, SC **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

____
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____
____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed:____________________________________ Date:________________________

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship:________________________ Witnessed by:________________________

Michael A. Epstein, MD, FACS
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