Aesthetic Surgery of Virginia

Enrique A. Silberblatt, MD, FACS
3505 Brambleton Ave. SW - Roanoke, VA 24018
(540) 776-1600 Fax: (540) 776-0082

Patient Information Profile

Patient Name:_______________________________________ Date___________________

Address:_________________________________ Nickname:________________________

City/State/Zip:___________________________ Social Security # _____-____-_____

Date of Birth :______________ Marital status:_____________ Gender (M/F)________

Home phone ____________________________ Work phone ________________________

Cell Phone _____________________________ E-Mail Address______________________

May we contact you: By phone?__________ Contact Number Preferred: Cell/home/Work

Employer:______________________________ Occupation:____________________

Emergency contact:____________________________ Phone:__________________________

Relation to patient (spouse/friend/parent):_________________________

How did you hear about Dr. Silberblatt? ___________________________

What do you wish to discuss today?: ____
____

Have you ever had cosmetic surgery? __________

If so, please list procedure, date of surgery, and the doctor who performed the procedure:
____

____

Certification and Acknowledgement:

I certify that all foregoing information and all information supplied by me, as part of the registration process is correct. I also acknowledge receipt of the Aesthetic Surgery of Virginia and Advanced Medical Skin Care Notice of Information Practices and Privacy Statement.

Signature____Date___________________________
(Patient/Responsible Party if Patient is a Minor)

DEEMED CONSENT TO HIV AND HBV TESTING

In case a healthcare worker of this Office should be stuck by a needle or is directly exposed to fluids during your care which may transmit HIV virus(the virus which causes AIDES) and HBV (the virus which causes Hepatitis B), in accordance with Section 32.1-451 of the Virginia Code, you will be deemed to have consented to the Office's right to draw blood for testing of the HIV and HBV virus and the release of such test results to this Office and to the worker who suffered the exposure.

Signature____ Date______________________________
(Patient/Responsible Party if Patient is a Minor)

Aesthetic Surgery of Virginia

Patient Name: ____ Date: __________

Height: ________________ Weight :_______________ Age: _______

MEDICATIONS: *List dose or number of pills per day*

Prescription Drugs | Non-Prescription (Vitamins;Herbs)

_________________________________ | _________________________________
_________________________________ | _________________________________
_________________________________ | _________________________________
_________________________________ | _________________________________

Please Circle

Regular Aspirin Use:	Yes	No	Dosage & Frequency: ______________
Anti-inflammatories	Yes	No	Dosage & Frequency: ______________
Cortisone Injections Past Year	Yes	No	Dosage & Frequency: ______________
Accutane	Yes	No	Dosage & Frequency: ______________
Latex Allergy:	Yes	No	
Tape Allergy:	Yes	No	
Drug Allergy:	Yes	No	List drug(s) and type of reaction:

____

Do you use tobacco? Yes No Alcohol use (describe)______________________________

Have you ever received a transfusion: Yes No If yes, what year: ____________________________

Have you been tested for HIV? Yes No If yes, what year? __________ Test results: Positive Negative

Do you wear:

Contact lenses: Yes No Eye glasses Yes No Hearing aid: Yes No Dentures Yes No

Previous Surgery, year and type of procedure: ______________________________________

____

Personal Past History: Have you ever had:

Abnormal Bleeding: Yes No	Asthma: Yes No	Hypertension:	Yes No
Abnormal Clotting: Yes No	Diabetes: Yes No	Sleep Apnea:	Yes No
Acid Regurgitation: Yes No	Fainting Spell: Yes No	Snoring:	Yes No
Anemia: Yes No	Heart Attack: Yes No	Weight Change past 12 mo.:	Yes No
Angina: Yes No	Hepatitis: Yes No	Other Serious Illness:	Yes No

Complications due to or during anesthesia: Yes No

Please describe questions with a "Yes" answer:____________________________________

____

____

Indicate the type(s) if anesthesia received in the past, list any complications/reactions you experiences:

- Local anesthesia – complications/reactions:______________________________
- General anesthesia – complications/reactions:______________________________
- Spinal/Epidural – complications/reactions:______________________________

Primary Care Physician (name) ________________________________ Date last seen: ________

(if out of area - Address) ____________________________ Telephone (____)______________

FEMALE PATIENTS ONLY:

Are you pregnant now: Yes No Number of previous pregnancies: _______ Number of children: _______

Last menstrual period: __________ Did you breast feed? Yes No

FAMILY HISTORY: Have any blood relatives ever had the following problems:

Abnormal Bleeding: Yes No	Kidney Disease: Yes No	Coronary Surgery: Yes No
Abnormal Clotting: Yes No	Diabetes: Yes No	Tuberculosis: Yes No
Heart Attack: Yes No	Cancer: Yes No	Hypertension: Yes No
Complications due to or during anesthesia: Yes No		Other Serious Illness: Yes No

Please describe questions with a "Yes" answer: __________________________________

____

Advanced Medical Skin Care

Skin Evaluation

Patient Name: ____ Sex: _________

Have you ever used Acutane? **Yes** **No** (if yes, when)? ___________________________

Have you used topical medication? **Yes** **No** If so which ones?
Acne Medication ___ RetinA ____ Glycolic Acid ______ Other: ______________________

Have you ever has a skin allergy? **Yes** **No**
If yes, from what? Cosmetics ____ Fabrics _____ Aspirin ____ Other _________________
Do you have rashes? **Yes** **No**

How do you tan?
I. Burn ____ II. Usually Burn ____ III Sometimes Burn ____
IV. Rarely Burn ____ V. Never Burn (Brown) _____ VI. Never Burn (Black) ____

Is your pigmentation Even ____ Uneven ____ Do you have a Birthmark **Yes** **No**

Do you have vascularities? **Yes** **No**
If yes, which areas? Nose area ____ Cheek area ____ Chin Area ____ Forehead ____

Do you have any history of acne or periodic breakout? **Yes** **No**
If yes, in what ways? Pimples ____ White-heads ____ Blackheads ____
Enlarged Pores ____ Flakiness ____Acne Scars ____ Cysts ____

Do you have facial wrinkles? **Yes** **No**
If yes, what kind? Deep Wrinkles ____ Crows Feet ____ Fine Lines ____

Do you form thick or raised scarring from a cut or burn? **Yes** **No**
Do you wax or use depilatories on your face? **Yes** **No**
Do you get cold sores? **Yes** **No**

How do you want to improve your skin? ______________________________________

What specific area do you want to treat? Face ____ Neck ____ Chest ____ Back ____
Hands ____ Forearms ____ Lower Legs ____ Other ____________________________

Signature: ____________________________________ Date: _____________________